PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/30/2018 5:10 pm use only] Manually submitted cost report 7] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. 6. Date Received: 7. Contractor No. Contractor]Cost Report Status 10. NPR Date: (1) As Submitted 11. Contractor's Vendor Code: use only (1) As submitted (2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter (3) Settled with Audit 9. [N] Final Report for this Provider CCN number of times reopened = 0-9. (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HENDRICKS REGIONAL HEALTH (15-0005) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
Ti tl e	 e
Date	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	22, 058	-28, 569	0	82, 298	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
200.00	Total	0	22, 058	-28, 569	0	82, 298	200.00

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

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: 5/30/2018 4:38 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1000 EAST MAIN STREET 1.00 PO Box: 1.00 State: IN Zip Code: 46122-1409 County: HENDRICKS 2.00 City: DANVILLE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Туре 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal HENDRICKS REGIONAL 150005 26900 07/01/1966 N 3.00 HFAI TH Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15 00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 01/01/2017 20.00 20.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2017 Type of Control (see instructions) 21.00 21.00 2 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate γ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Υ Υ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23 00 3 N 23 00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

	In-State	In-State	Out-of	Out-of	Medicaid	Other	
	Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
	paid days	eligible	Medi cai d	Medi cai d		days	
		unpai d	paid days	eligible			
		days	'	unpai d			
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00 If this provider is an IPPS hospital, enter the	310	2, 226	0	0	1, 096	0	24. 00
in-state Medicaid paid days in column 1, in-state							
Medicaid eligible unpaid days in column 2,							ĺ
out-of-state Medicaid paid days in column 3,							ĺ
out-of-state Medicaid eligible unpaid days in column							
4, Medicaid HMO paid and eligible but unpaid days in							ĺ
column 5, and other Medicaid days in column 6.							
25.00 If this provider is an IRF, enter the in-state	0	0	0	0	0		25. 00
Medicaid paid days in column 1, the in-state		ū					20.00
Medicaid eligible unpaid days in column 2,							ĺ
out-of-state Medicaid days in column 3, out-of-state							ĺ
Medicaid eligible unpaid days in column 4, Medicaid							ĺ
							ĺ
HMO paid and eligible but unpaid days in column 5.			l	l	I	l	1

Heal th	Financial Systems HENDRIC	CKS REGI	ONAL HEALTH		Li	n Lie	u of For	m CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der CC	F	eriod: rom 01/01/		Workshe Part I		
				T	o 12/31/	2017	Date/Ti 5/30/20		
					Urban/Rur 1.00		Date of 2.0		
	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo			ginning of the		1	2.0	, 0	26. 00
27. 00	Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) sta r "2" fo	atus at the end or rural. If ap	d of the cost oplicable,		1			27. 00
35. 00	If this is a sole community hospital (SCH), enter the			CH status in		0			35. 00
	pricet in the cost reporting period.				Begi nni		Endi		
36. 00	Enter applicable beginning and ending dates of SCH s	tatus '	Subscript line	36 for number	1. 00		2.0	00	36. 00
37. 00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.	es.	·			0			37. 00
37. 01	ls this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f								37. 01
38. 00	<pre>instructions) If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.</pre>								38. 00
	enter subsequent dates.				Y/N		Y/		
39. 00	Does this facility qualify for the inpatient hospita	l paymei	nt adjustment 1	for low volume	1. 00 N		2. C N		39. 00
	hospitals in accordance with 42 CFR §412.101(b)(2)(i for yes or "N" for no. Does the facility meet the mi with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in colum instructions)	l eage 'r	equirements in	accordance					
40. 00	Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. I	Enter "Y" for y		N		N		40. 00
	ino thi cordinit 2, for discharges on or after october i	. (300	riisti deti olis)			V 1. 00	XVIII	XI X	
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	nt for (di sproporti onat	te share in acc	cordance	N	Y	N	45. 00
46. 00	Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	eption [.] t. L, P	for extraordina t. III and Wkst	ary circumstand t. L-1, Pt. I 1	ces through	N	N	N	46. 00
47. 00 48. 00	ls this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen					N N	N N	N N	47. 00 48. 00
56. 00	Teaching Hospitals Is this a hospital involved in training residents in	approv	ed GME programs	s? Enter "Y" f	for yes	N			56. 00
57. 00	or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	r yes o th of tl Y", com	r "N" for no ir his cost report plete Worksheet	n column 1. If ting period? E	column 1 Enter "Y"				57. 00
58. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim			ans' services a	as	l N			58. 00
	defined in CMS Pub. 15–1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If ye	comple	te Wkst. D-5.			N N			59. 00
34.00	ALE COSTS CLAIMED ON THE 100 OF WOLKSHEET A: 11 ye	s, comp	Tete WKSt. D-2,	NAHE 413.85 Y/N	Workshee Li ne	et A #	Pass-Th Qualifi Criterio	cati on	
				1. 00	2. 00		3. 0	00	
	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?			N					60. 00
ľ		Y/N	I ME	Direct 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	61.00
	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)								61. 01
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,								61. 02
	and primary care FTEs added under section 5503 of								

Health Financial Systems HENDRIC	CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/30/2018 4:3	pared:
	Y/N	I ME	Direct GME	I ME	Direct GME	<u> Б.ш.</u>
	1. 00	2. 00	3. 00	4.00	5. 00	
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being						61. 04
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						01.00
cure or general surgery. (see mistractrons)	Pro	ogram Name	Program Code	FTE Count	Direct GME FTE Count	
44 49 99 11 575 1 11 44 95 1 19		1.00	2. 00	3.00	4.00	(1.10
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0.00	61. 20
ACA Davisis and Affection the Health Decourses and Co		۸ + : + :	(UDCA)		1. 00	
ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital				iod for which	0.00	62. 00
your hospital received HRSA PCRE funding (see instru- 62.01 Enter the number of FTE residents that rotated from	ctions)					62. 01
during in this cost reporting period of HRSA THC pro- Teaching Hospitals that Claim Residents in Nonprovid			ns)			
63.00 Has your facility trained residents in nonprovider so "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this co			N	63. 00
	010 11110	o o r em ough	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te	Hospi tal	2))	
10 U 5504 6 U 401 0 V 575 0 U 1			1. 00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in N period that begins on or after July 1, 2009 and befo	•	9	inis base yea	r is your cost r	reporting	
64.00 Enter in column 1, if line 63 is yes, or your facili in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighter resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	ty trair n-primar all nor d non-pr n columr instruc	ned residents by care provider imary care a 3 the ratio	0. (
Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
1.00		2. 00	3. 00	4.00	5. 00	

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: 5/30/2018 4:38 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs (col. 3 + col FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col. Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTES FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 0.000000 67.00 67.00 Enter in column 1, the program 0.00 0.00 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

	4)). (see instructions)								
						1. 00	2. 00	3.00	
	Inpatient Psychiatric Facility F	PPS							
70.00	Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or does it conta	in an IPF subp	rovi der?	N			70.00
	Enter "Y" for yes or "N" for no								
71.00	If line 70 is yes: Column 1: Did	I the facility have ar	n approved GME teachin	ng program in t	he most	N		0	71.00
	recent cost report filed on or b	efore November 15, 20	004? Enter "Y" for ye	es or "N" for r	no. (see				
	42 CFR 412.424(d)(1)(iii)(c)) Co	lumn 2: Did this faci	lity train residents	in a new teach	ni ng				
	program in accordance with 42 CF	R 412.424 (d)(1)(iii))(D)? Enter "Y" for ye	s or "N" for r	10.				
	Column 3: If column 2 is Y, indi	cate which program ye	ear began during this	cost reporting	period.				
	(see instructions)								
	Inpatient Rehabilitation Facilit	y PPS							
75.00	Is this facility an Inpatient Re	habilitation Facility	y (IRF), or does it co	ntain an IRF		N			75.00
	subprovider? Enter "Y" for yes	and "N" for no.							
76.00	If line 75 is yes: Column 1: Did	I the facility have ar	n approved GME teachin	ng program in t	he most	N		0	76.00
	recent cost reporting period end	ling on or before Nove	ember 15, 2004? Enter	"Y" for yes or	"N" for				
	no. Column 2: Did this facility	train residents in a	new teaching program	in accordance	with 42				
	CFR 412.424 (d)(1)(iii)(D)? Ente	r "Y" for yes or "N"	for no. Column 3: If	column 2 is Y,					
	indicate which program year bega	n durina this cost re	eportina period. (see	instructions)					

divided by (column 3 + column

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0005	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S Part I Date/Time P 5/30/2018 4	repared:
				1.00	
Long Term Care Hospital PPS					
 .00 Is this a long term care hospital (LTCH)? Enter "Y" for yes .00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no. TEFRA Providers 			ng period? Enter	N N	80. 00 81. 00
.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i).00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ıl classified	under sectio	١	N	87. 00
1000(d)(1)(b)(v1): Effect 1 101 yes 01 N 101 Ho.			V	XI X	
			1. 00	2.00	
Title V and XIX Services				·	
.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	ıl services? E	nter "Y" for	N	Y	90.00
.00 Is this hospital reimbursed for title V and/or XIX through 1	he cost repor	t either in	N	Υ	91.00
full or in part? Enter "Y" for yes or "N" for no in the appl					
.00 Are title XIX NF patients occupying title XVIII SNF beds (du		ion)? (see		N	92.00
instructions) Enter "Y" for yes or "N" for no in the applica .00 Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	N	93. 00
"Y" for yes or "N" for no in the applicable column.					
.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94.00
applicable column. .00 If line 94 is "Y", enter the reduction percentage in the app	olicable colum	n	0. 00	0.00	95. 0
.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			N N	N N	96. 0
applicable column.					
.00 fline 96 is "Y", enter the reduction percentage in the app. .00 Does title V or XIX follow Medicare (title XVIII) for the in			0. 00 Y	0. 00 Y	97. 0
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" 1			T T	T T	90.0
column 1 for title V, and in column 2 for title XIX.	. ,				
.01 Does title V or XIX follow Medicare (title XVIII) for the re	porting of ch	arges on Wks	t. Y	Y	98. 0
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti	tle V, and in	column 2 for			
	tle XIX. es title V or XIX follow Medicare (title XVIII) for the calculation of observation Y				
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o	or "N" for no	in column 1			
for title V, and in column 2 for title XIX. .03 Does title V or XIX follow Medicare (title XVIII) for a crif	ical access h	ospital (CAU)) N	N	98. 0
reimbursed 101% of inpatient services cost? Enter "Y" for ye				l IN	70.0
for title V, and in column 2 for title XIX.					
.04 Does title V or XIX follow Medicare (title XVIII) for a CAH			ı N	N	98. 0
outpatient services cost? Enter "Y" for yes or "N" for no ir in column 2 for title XIX.	i corumn i for	title v, and	1		
.05 Does title V or XIX follow Medicare (title XVIII) and add ba	ick the RCE di	sallowance or	n Y	Υ	98. 0
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in o	olumn 1 for t	itle V, and i	n		
column 2 for title XIX. .06 Does title V or XIX follow Medicare (title XVIII) when cost	raimbursed fo	r Wket D			98. 0
Pts. I through IV? Enter "Y" for yes or "N" for no in column			· ·	'	70.0
column 2 for title XIX.					
Rural Providers			N	I	105 0
5.00 Does this hospital qualify as a CAH? 6.00 If this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of pavme	nt N		105. 0 106. 0
for outpatient services? (see instructions)		. 3			
7.00 If this facility qualifies as a CAH, is it eligible for cost			N		107. 0
training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.					
reimbursed. If yes complete Wkst. D-2, Pt. II.	the p	.g 3 00.			
8.00 is this a rural hospital qualifying for an exception to the	CRNA fee sche	dul e? See 42	2 N		108. 0
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupation	al Speech	Respi ratory	v
	1. 00	2.00	3. 00	4.00	,
9.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 00
			•		
0.0001.1.11.1.1.1.1.1.1.1.1.1.1.1.1.1.1			24404	1.00	440 -
0.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter '				N	110. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	HEALTH rovider CCN: 15-0005	Peri od:	ieu of Form CM Worksheet S	
OSITIAL AND HOSITIAL HEALTH CARE COMMERN TENTH TOATION DATA	TOVI GET CON. 13-0003	From 01/01/201 To 12/31/201	17 Part I	repared
11.00 f this facility qualifies as a CAH, did it participate in the F	rontier Community	1. 00 N	2.00	111.
Health Integration Project (FCHIP) demonstration for this cost r "Y" for yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is partici Enter all that apply: "A" for Ambulance services; "B" for additi- for tele-health services.	eporting period? Enter 1 is Y, enter the pating in column 2.			
		1.	00 2.00 3.0	0
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" is yes, enter the method used (A, B, or E only) in column 2. If a either "93" percent for short term hospital or "98" percent for psychiatric, rehabilitation and long term hospitals providers) b. Pub. 15-1, chapter 22, §2208. 1.	column 2 is "E", enter r long term care (incl	in column udes	N O	115.
16.00 s this facility classified as a referral center? Enter "Y" for 17.00 s this facility legally-required to carry malpractice insurance no.			N Y	116. 117.
18.00 Is the malpractice insurance a claims-made or occurrence policy?	Enter 1 if the policy	/ is	1	118.
praim-made. Litter 2 if the policy is occurrence.	Premi ums	Losses	Insurance	
18.01 List amounts of malpractice premiums and paid losses:	1.00	2.00	3.00	0118.
	, , , , , , , , , , , , , , , , , , , ,			
18.02Are malpractice premiums and paid losses reported in a cost cent	er other than the	1. 00 N	2.00	118.
Administrative and General? If yes, submit supporting schedule and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harles \$3121 and applicable amendments? (see instructions) Enter in col	mless provision in ACA	A N	N	119. 120.
"N" for no. Is this a rural hospital with < 100 beds that qualif Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.	ies for the Outpatient (see instructions)			
21.00 Did this facility incur and report costs for high cost implantab patients? Enter "Y" for yes or "N" for no.	ie devices charged to	Y		121.
22.00 Does the cost report contain healthcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included.			5. 00	122.
Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for ye	s and "N" for no. If	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.	the certification date	•		126.
7.00 If this is a Medicare certified heart transplant center, enter t	he certification date			127.
in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter t	he certification date			128.
in column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified lung transplant center, enter the column 1 and termination date, if applicable, in column 2.	e certification date i	n		129.
0.00 If this is a Medicare certified pancreas transplant center, ente				130.
date in column 1 and termination date, if applicable, in column in 1.00. This is a Medicare certified intestinal transplant center, en	ter the certification			131.
date in column 1 and termination date, if applicable, in column : 2.00 If this is a Medicare certified islet transplant center, enter t				132.
in column 1 and termination date, if applicable, in column 2. 3.00 If this is a Medicare certified other transplant center, enter t	he certification date			133.
in column 1 and termination date, if applicable, in column 2. 34.00 If this is an organ procurement organization (OPO), enter the OPO and termination date, if applicable, in column 2.	O number in column 1			134.
All Providers				
40.00 Are there any related organization or home office costs as defin- chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes,		N S		140.

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: To 5/30/2018 4:38 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143.00 Ci ty: State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν N 148 00 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no N 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 0168.00

reasonable cost incurred for the HII assets (see instructions)			
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N	"), enter the	0.0	0169. 00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170. 00
	1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N		0 171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

Heal th	Financial Systems HENDRICKS REG	IONAL HEALTH		In Li∈	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Peri od:	Worksheet S-2	2
				From 01/01/2017 o 12/31/2017		nared:
				0 12/31/2017	5/30/2018 4: 3	
				Y/N	Date	
				1. 00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	N for all NO re	esponses. Enter	all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the	e beainnina of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in					
			Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2.00	Has the provider terminated participation in the Medicare I		N			2. 00
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	mn 3, V Tor				
3.00	Is the provider involved in business transactions, including	ng management	N			3. 00
0.00	contracts, with individuals or entities (e.g., chain home					0.00
	or medical supply companies) that are related to the provide	der or its				
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other	er similar				
	relationships? (see instructions)		Y/N	Typo	Date	
			1.00	7ype 2. 00	3.00	
	Financial Data and Reports		1.00	2.00	3.00	
4.00	Column 1: Were the financial statements prepared by a Cer	tified Public	Υ	А		4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C"	for Compiled,				
	or "R" for Reviewed. Submit complete copy or enter date available.	ailable in				
г оо	column 3. (see instructions) If no, see instructions.		N.			F 00
5.00	Are the cost report total expenses and total revenues differentiations on the filed financial statements? If yes, submit revenues to the filed financial statements of the cost report total expenses and total revenues differentiations.		N			5. 00
	Those of the fired financial statements? If yes, submit rec	CONCITTATION.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities			1		
6.00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	N		6. 00
	the legal operator of the program?					7.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see in		de ale construe de la co	N		7.00
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	a durring the	N		8. 00
9. 00	Are costs claimed for Interns and Residents in an approved	graduate medic	cal education	N		9. 00
	program in the current cost report? If yes, see instruction	•				
10.00	Was an approved Intern and Resident GME program initiated	or renewed in t	the current	N		10.00
	cost reporting period? If yes, see instructions.					1
11. 00	Are GME cost directly assigned to cost centers other than	I & Rin an App	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
	Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	tions.		Υ	12. 00
13.00	If line 12 is yes, did the provider's bad debt collection	policy change o	during this cos	st reporting	N	13. 00
	period? If yes, submit copy.					1
14.00	If line 12 is yes, were patient deductibles and/or co-payme	ents warved? If	yes, see inst	ructions.	N	14. 00
15 00	Bed Complement Did total beds available change from the prior cost reporti	ing period2 lf	vas saa instr	ructions	N	15. 00
13.00	Total beds available change from the pirol cost report		rt A		rt B	13.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only?	Υ	04/25/2018	Υ	04/25/2018	16. 00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 (see instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N	•	17. 00
	totals and the provider's records for allocation? If			,,		55
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report			,,		55
	information? If yes, see instructions.					
	·				-	

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0005	Peri od: From 01/01/2017	Worksheet S-2 Part II	
				To 12/31/2017	Date/Time Pre 5/30/2018 4:3	epared
		Descri	pti on	Y/N	Y/N	DO PIII
)	1.00	3. 00	
. 00	If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20.
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)		1.00	
	Capital Related Cost		•			
	Have assets been relifed for Medicare purposes? If yes, see				N	22.
. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made dur	ing the cost	N	23.
. 00	Were new leases and/or amendments to existing leases entered If yes, see instructions	d into during	this cost re	porting period?	N	24.
00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see	N	25.
. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	e cost renorti	na period? L	f ves. see	N	26.
	instructions.	·	0 .			
. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? If	yes, submit	N	27
	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	tered into dur	ing the cost	reporting	N	28
00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or I	bond funds (De	bt Service R	eserve Fund)	N	29
00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur		debt? If yes	, see	N	30
00	instructions. Has debt been recalled before scheduled maturity without is: instructions.	suance of new	debt? If yes	, see	N	31
	Purchased Services					
00	Have changes or new agreements occurred in patient care servarrangements with suppliers of services? If yes, see instruc		d through co	ntractual	N	32
. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appl no, see instructions.		g to competi	tive bidding? If	N	33
	Provi der-Based Physi ci ans					
00	Are services furnished at the provider facility under an are	rangement with	provi der-ba	sed physi ci ans?	N	34
00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi: physicians during the cost reporting period? If yes, see in:		its with the	provi der-based	N	35
	physicians during the cost reporting period: it yes, see in	structions.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs			NI NI		1 2/
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pro	epared by the	home office?	N N		36
	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi					38
	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other	of the home o	ffi ce.			39
00	see instructions. If line 36 is yes, did the provider render services to the I	home office?	If yes, see	N		40
	instructions.					
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
00	held by the cost report preparer in columns 1, 2, and 3,	MI CHAEL		ALESSANDRI NI		41
00	respectively. Enter the employer/company name of the cost report preparer.	BLUE & CO., LL	С			42
00		317. 713. 7959		MALESSANDRI NI @I	BLUFANDCO, COM	43

Heal th	Financial Systems HENDRICKS	REGI OI	NAL HEALTH	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0005	riod: om 01/01/2017 12/31/2017		pared:
					,	ļ
			3. 00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position		RECTOR			41. 00
	held by the cost report preparer in columns 1, 2, and 3	,				
	respecti vel y.					
42. 00	Enter the employer/company name of the cost report					42. 00
	preparer.					
43.00	Enter the telephone number and email address of the cos	t				43. 00
	report preparer in columns 1 and 2, respectively.					

Health Financial Systems HENDRIC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0005

				To	o 12/31/2017	Date/Time Prep 5/30/2018 4:38	
						I/P Days / 0/P	D DIII
						Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	115	41, 975	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO I PF Subprovi der						3. 00
4.00	HMO I RF Subprovi der						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		115	41, 975	0. 00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31. 00	12	4, 380	0. 00	0	8. 00
9. 00	CORONARY CARE UNIT	31.00	12	4, 300	0.00	U	9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY	43. 00				0	13. 00
14. 00	Total (see instructions)	43.00	127	46, 355	0. 00	Ö	14. 00
15. 00	CAH visits		127	40, 333	0.00	0	15. 00
16. 00	SUBPROVI DER - I PF					Ü	16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	44. 00	0	0		0	19. 00
20. 00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		127				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		0	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days						33. 00
33. UI	LTCH site neutral days and discharges						33. 01

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0005

				Т	o 12/31/2017	Date/Time Prep 5/30/2018 4:38	
		I/P Days	/ O/P Visits	/ Tri ps	Full Time E		5 piii
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	6, 690	310	16, 351			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 991	3, 315				2. 00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO I RF Subprovi der	0	0	0			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	U	0	0			5. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF	6, 690	0 310	14 2E1			6. 00 7. 00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0, 090	310	16, 351			7.00
8. 00	INTENSIVE CARE UNIT	904	0	1, 809			8. 00
9. 00	CORONARY CARE UNIT	70 1	J	1,007			9. 00
10.00							10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11. 00
	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00			0	3, 063			13.00
14.00	Total (see instructions)	7, 594	310	21, 223	0.00	1, 576. 00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF						17.00
	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
	NURSING FACILITY						20.00
	OTHER LONG TERM CARE						21. 00
	HOME HEALTH AGENCY						22. 00
	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00							24.00
	HOSPICE (non-distinct part)	O	0	0			24. 10
25. 00							25. 00 26. 00
26. 00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0. 00	26. 00
	Total (sum of lines 14-26)	٩	U	U	0.00	1, 576. 00	27. 00
	Observation Bed Days		0	2, 018		1, 576.00	28. 00
29. 00	3	0		2,010			29. 00
	Employee discount days (see instruction)	J		0			30.00
31. 00	. ,			0			31. 00
	Labor & delivery days (see instructions)	n	7	262			32. 00
32. 01	Total ancillary labor & delivery room	1	1	0			32. 01
	outpatient days (see instructions)						
	LTCH non-covered days	o					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01

				To	12/31/2017	Date/Time Prep 5/30/2018 4:38	
		Full Time Equivalents		Di sch	arges		
	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		C	2, 062	58	5, 679	1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			563	764		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00		2 0/2	F.0	F 470	13.00
14. 00 15. 00	Total (see instructions)	0. 00	C	2, 062	58	5, 679	
	CAH visits						15. 00
16. 00 17. 00	SUBPROVIDER - I PF						16.00
18.00	SUBPROVI DER - I RF SUBPROVI DER						17. 00 18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20. 00	NURSING FACILITY	0.00					20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC	·					25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27.00
28. 00	Observation Bed Days						28.00
29. 00	Ambul ance Tri ps						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0		l	33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Peri od: | Peri

					To	12/31/2017	Date/Time Prep 5/30/2018 4:3	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries			Average Hourly Wage (col. 4 ÷	
				(from Wkst. A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
	PART II - WAGE DATA	1. 00	2.00	3.00	4. 00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see instructions)	200. 00	123, 208, 498	0	123, 208, 498	3, 278, 718. 00	37. 58	1.00
2.00	Non-physician anesthetist Part		0	О	0	0.00	0.00	2. 00
3.00	Non-physician anesthetist Part		0	О	0	0.00	0.00	3. 00
4.00	B Physician-Part A -		3, 011	0	3, 011	20. 00	150. 55	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0.00	0. 00	4. 01
5. 00	Physician and Non Physician-Part B		8, 383, 277	0	8, 383, 277	32, 593. 00		1
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	О	0	0.00	0.00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	О	0	0.00	0.00	7. 01
0.00	programs)					0.00	0.00	0.00
8. 00	Home office and/or related organization personnel		U	0		0. 00		
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 40, 864, 972	0	-	0. 00 799, 100. 00		1
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		1, 946, 873	0	1, 946, 873	17, 806. 00	109. 34	11. 00
12. 00	Contract Labor: Top Level		0	О	0	0.00	0. 00	12. 00
	management and other management and administrative							
13. 00	services Contract Labor: Physician-Part		1, 011, 753	0	1, 011, 753	9, 759. 00	103. 67	13. 00
14. 00	A - Administrative Home office and/or related orgainzation salaries and		0	0	0	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		0	0	0	0. 00	0.00	14. 01
14. 02	Related organization salaries		0	Ō	0	0.00	0.00	14. 02
15. 00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0.00	0. 00	16. 00
17. 00	Wage-related costs (core) (see		21, 835, 329	0	21, 835, 329			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
19. 00	(see instructions) Excluded areas		8, 585, 915	0	8, 585, 915			19. 00
20. 00	Non-physician anesthetist Part		0, 303, 413	0				20.00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A - Administrative		2, 442	0	2, 442			22. 00
22. 01	Physician Part A - Teaching		0	О	_			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		1, 206, 043	0	1, 206, 043			23. 00 24. 00
25. 00	Interns & residents (in an		0	ő	o o			25. 00
25. 50	approved program) Home office wage-related		0	0	0			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0	0	0			25. 52
	- Administrative - wage-related (core)							
25. 53	Home office & Contract Physicians Part A - Teaching -		0	0	0			25. 53
	wage-related (core) OVERHEAD COSTS - DIRECT SALARIE	·s						-
	Employee Benefits Department	4. 00			,			26. 00
27. 00	Administrative & General	5. 00	16, 659, 233	-1, 119, 116	15, 540, 117	339, 299. 00	45. 80	27. 00

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Peri od: | Peri

					'	0 12/31/2017	5/30/2018 4: 38	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		4, 823, 816	0	4, 823, 816	18, 357. 00	262. 78	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00		0	0	0.00		29. 00
30.00	Operation of Plant	7. 00		l .	2, 584, 991			30.00
31. 00	Laundry & Linen Service	8. 00	346, 844	0	346, 844	22, 582. 00	15. 36	31. 00
32.00	Housekeepi ng	9. 00	2, 141, 645	0	2, 141, 645	135, 423. 00	15. 81	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	1, 793, 116	-1, 283, 712	509, 404	29, 639. 00	17. 19	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36. 00	Cafeteri a	11. 00	0	1, 283, 712	1, 283, 712	73, 022. 00	17. 58	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13. 00	2, 133, 391	0	2, 133, 391	60, 908. 00	35. 03	38.00
39.00	Central Services and Supply	14. 00	785, 696	0	785, 696	40, 428. 00	19. 43	39.00
40.00	Pharmacy	15. 00	2, 092, 668	0	2, 092, 668	55, 677. 00	37. 59	40.00
41.00	Medical Records & Medical	16. 00	0	1, 119, 116	1, 119, 116	53, 817. 00	20. 79	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	1, 810, 200	0	1, 810, 200	58, 274. 00	31. 06	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2017 | Part III | To 12/31/2017 | Date/Time Prepared: | From CMS-2552-10 | Part III Provider CCN: 15-0005

							5/30/2018 4: 3	8 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		119, 649, 037	0	119, 649, 037	3, 264, 482. 00	36. 65	1. 00
	instructions)							
2.00	Excluded area salaries (see		40, 864, 972	0	40, 864, 972	799, 100. 00	51. 14	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		78, 784, 065	0	78, 784, 065	2, 465, 382. 00	31. 96	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		2, 958, 626	0	2, 958, 626	27, 565. 00	107. 33	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		21, 837, 771	0	21, 837, 771	0.00	27. 72	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		103, 580, 462	0	103, 580, 462	2, 492, 947. 00	41. 55	6. 00
7.00	Total overhead cost (see		36, 688, 283	0	36, 688, 283	1, 043, 032. 00	35. 17	7. 00
	instructions)							

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0005	
		From 01/01/2017 Part IV
		To 12/21/2017 Doto/Time Decembed.

	To 12/31/2017	Date/Time Prep 5/30/2018 4:38	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	3, 269, 347	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	5, 677, 191	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	-1, 129	5. 00
6.00	Legal /Accounting/Management Fees-Pensi on Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST	•	1
8.00	Health Insurance (Purchased or Self Funded)	16, 659, 195	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	1
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Health Insurance (Purchased)	0	•
9. 00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
	Life Insurance (If employee is owner or beneficiary)	181, 479	11. 00
	Accident Insurance (If employee is owner or beneficiary)	0	1
	Disability Insurance (If employee is owner or beneficiary)	2, 245	13.00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
	'Workers' Compensation Insurance	555, 327	15. 00
16. 00	'	0	16, 00
	Non cumulative portion)		
	TAXES	•	1
17.00	FICA-Employers Portion Only	5, 054, 288	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unemployment Insurance	19, 574	19. 00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER	•	1
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))	ļ ļ	1
22.00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	212, 211	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	31, 629, 728	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0005	Peri od: Worksheet S-3 From 01/01/2017 To 12/31/2017 Part V Part V Prepared: 5/30/2018 4:38 pm

	l.	0 12/31/2017	5/30/2018 4: 3	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2. 00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF	0	0	8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16. 00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Di al ysi s	0	0	17.00
18. 00	Other	0	0	18. 00

	Financial Systems AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovider CCN: 15-0005	Peri od:	u of Form CMS-2 Worksheet S-10	
)) 1	AL UNCOWN ENSATED AND THUTGENT CARE DATA	OVIGER CCN. 13-0003	From 01/01/2017		U
			To 12/31/2017	Date/Time Pre 5/30/2018 4:3	pared 8 pm
				1. 00	
	Uncompensated and indigent care cost computation				
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by line 202 colu	mn 8)	0. 319060	1. (
	Medicaid (see instructions for each line)				
00	Net revenue from Medicaid			10, 089, 564	1
00	Did you receive DSH or supplemental payments from Medicaid?		. 10	Y	3. (
00	If line 3 is yes, does line 2 include all DSH and/or supplemental		cai d?	Υ	4. (
00 00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid charges	ii wedi cai d		0 43, 091, 007	
00	Medicaid cost (line 1 times line 6)			13, 748, 617	
00	Difference between net revenue and costs for Medicaid program (li	ine 7 minus sum of L	ines 2 and 5 if	3, 659, 053	1
00	<pre>< zero then enter zero)</pre>			0,007,000	0. \
	Children's Health Insurance Program (CHIP) (see instructions for	each line)			Ī
00	Net revenue from stand-alone CHIP			0	9. (
0. 00	Stand-alone CHIP charges			0	
1. 00	Stand-alone CHIP cost (line 1 times line 10)			0	
2. 00	Difference between net revenue and costs for stand-alone CHIP (li	ine 11 minus line 9;	if < zero then	0	12.
	enter zero) Other state or local government indigent care program (see instru	actions for each lin	2)		
3. 00	Net revenue from state or local indigent care program (see institu			0	13.
4. 00	Charges for patients covered under state or local indigent care program (Not include Charges for patients covered under state or local indigent care program (Not include the Not include the			0	ı
7. 00	10)	or ogram (Not Therade	a ili ililes o oi	O	14.
5. 00	State or local indigent care program cost (line 1 times line 14)			0	15.
5. 00	Difference between net revenue and costs for state or local indig	gent care program (I	ine 15 minus line	0	16.
	13; if < zero then enter zero)				
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and state/local ind	igent care progran	ns (see	
7. 00		ding charity care		0	17.
3. 00	Government grants, appropriations or transfers for support of hos	spital operations		0	18.
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)	indigent care progra	ms (sum of lines	3, 659, 053	19.
	12 did 10)	Uni nsured	d Insured	Total (col. 1	
		pati ents		+ col . 2)	
		1. 00	2. 00	3. 00	
	Uncompensated Care (see instructions for each line)				
0. 00	Charity care charges and uninsured discounts for the entire facil	3, 983,	772 0	3, 983, 772	20.
1. 00	(see instructions)	ts (see 1 271	062 0	1 271 042	21.
1.00	Cost of patients approved for charity care and uninsured discount instructions)	ts (see 1, 271,	062	1, 271, 062	21.
2. 00	Payments received from patients for amounts previously written of	ff as	0 0	0	22.
00	charity care				
3. 00		1, 271,	062 0	1, 271, 062	23.
				1. 00	
4. 00	Does the amount on line 20 column 2, include charges for patient		h of stay limit		24.
5. 00	imposed on patients covered by Medicaid or other indigent care properties of the pro		am's length of	0	25.
5. 00	stay limit Total bad debt expense for the entire hospital complex (see insti	ructions)		21, 010, 665	26.
	Medicare reimbursable bad debts for the entire hospital complex (see histi	-		243, 487	1
/ (111)	Medicare allowable bad debts for the entire hospital complex (see	•		374, 595	1
7. 00 7. 01	The state of the s			20, 636, 070	1
7. 01	Non-Medicare bad debt expense (see instructions)				
	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exper	nse (see instruction	s)		1
7. 01 3. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exper Cost of uncompensated care (line 23 column 3 plus line 29)	nse (see instruction	s)	6, 715, 252 7, 986, 314	29.

Heal th	Financial Systems	HENDRICKS REGIO	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der Co	CN: 15-0005 F	'eri od:	Worksheet A	
					rom 01/01/2017		
				T	o 12/31/2017		
			2.1			5/30/2018 4: 3	8 pm
	Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		2.00	0.00	1. 00	0.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT		22, 718, 067	22, 718, 067	0	22, 718, 067	1.00
		1 51/ /02					
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 516, 683	3, 650, 562				4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	16, 659, 233	35, 413, 569			49, 683, 835	5. 00
7.00	00700 OPERATION OF PLANT	2, 584, 991	8, 014, 977	10, 599, 968	14, 026	10, 613, 994	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	346, 844	498, 534	845, 378	44, 076	889, 454	8. 00
9.00	00900 HOUSEKEEPI NG	2, 141, 645	1, 446, 426	3, 588, 071	-13	3, 588, 058	9.00
10.00	01000 DI ETARY	1, 793, 116	1, 942, 627			1, 060, 828	10.00
11. 00	01100 CAFETERI A	0	0	1		2, 674, 461	11.00
13. 00	01300 NURSING ADMINISTRATION	-	935, 955	1		3, 068, 807	13.00
		2, 133, 391					1
14. 00	01400 CENTRAL SERVICES & SUPPLY	785, 696	657, 763			1, 438, 413	14.00
15. 00	01500 PHARMACY	2, 092, 668	9, 849, 318				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0) C	2, 420, 719	2, 420, 719	16. 00
17.00	01700 SOCIAL SERVICE	1, 810, 200	627, 454	2, 437, 654	16, 850	2, 454, 504	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	·					1
30.00	03000 ADULTS & PEDI ATRI CS	12, 942, 483	5, 358, 911	18, 301, 394	-370, 960	17, 930, 434	30.00
31. 00	03100 NTENSI VE CARE UNI T	1, 685, 911	787, 752				31.00
	04300 NURSERY						
43.00		385, 680	153, 798				43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0) <u> </u>	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 390, 707	8, 548, 904	10, 939, 611	-1, 679, 204	9, 260, 407	50. 00
50. 01	05001 ENDOSCOPY	1, 063, 015	789, 099	1, 852, 114	-301, 458	1, 550, 656	50. 01
51.00	05100 RECOVERY ROOM	1, 281, 311	481, 460	1, 762, 771	-99, 185	1, 663, 586	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	855, 696	182, 352				52. 00
53. 00	05300 ANESTHESI OLOGY	5, 297, 545	1, 277, 139				•
							•
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 225, 302	2, 924, 564				54.00
54. 01	05401 RADI ATI ON-ONCOLOGY	1, 214, 474	18, 684, 531			20, 018, 458	54. 01
56. 00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	162, 850	252, 365	415, 215	-1, 362	413, 853	56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	591, 669	610, 054	1, 201, 723	-407, 482	794, 241	59. 00
60.00	06000 LABORATORY	2, 685, 575	5, 284, 173	7, 969, 748	2, 946	7, 972, 694	60.00
64.00	06400 I NTRAVENOUS THERAPY	934, 304	348, 939	1, 283, 243	134, 356	1, 417, 599	64.00
65. 00	06500 RESPI RATORY THERAPY	1, 991, 723	1, 037, 434				1
66. 00	06600 PHYSI CAL THERAPY	5, 037, 181	2, 902, 716				66.00
	06700 OCCUPATI ONAL THERAPY						1
67. 00	1 1	386, 672	134, 095			542, 630	67.00
68. 00	06800 SPEECH PATHOLOGY	269, 582	111, 131			380, 713	68. 00
69. 00	06900 ELECTROCARDI OLOGY	557, 812	481, 374	1, 039, 186	-4, 847	1, 034, 339	69. 00
69. 01	06901 CARDI AC REHAB	450, 606	176, 698	627, 304	-4, 445	622, 859	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	96, 499	33, 921	130, 420	-38	130, 382	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	o	0		6, 071, 967	6, 071, 967	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0				
73. 01	07301 ULTRA SOUND	464, 092	182, 638				
	07400 RENAL DIALYSIS					101 475	
/4. UU	000	0	192, 303	192, 303	-828	191, 475	/4.00
	OUTPATIENT SERVICE COST CENTERS	. ,				,	
90. 00	09000 CLI NI C	1, 689, 250	4, 774, 005				90.00
91. 00	09100 EMERGENCY	3, 819, 120	2, 850, 907	6, 670, 027	-360, 638	6, 309, 389	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS			•			1
118.00		82, 343, 526	144, 316, 515	226, 660, 041	4, 689, 305	231, 349, 346	118 00
110.00	NONREI MBURSABLE COST CENTERS	02, 010, 020	111,010,010	220,000,011	1, 007, 000	201, 017, 010	1110.00
102.00	19200 PHYSICIANS' PRIVATE OFFICES	33, 346, 454	20 072 701	E4 210 1EE	4 407 120	49, 822, 016	102 00
			20, 972, 701				
	19201 HEALTH TRACKS	2, 979, 753	1, 188, 946			4, 095, 004	
	07950 PRIMARY CARE CLINIC	1, 114, 184	2, 247, 897			3, 347, 134	
	07951 PARTNERS IN CARE	645, 413	266, 096			887, 564	
194. 02	07952 OCCUPATIONAL MEDICINE	255, 634	696, 685	952, 319	-43, 488	908, 831	194. 02
194.03	07953 FOUNDATI ON	148, 828	82, 113			230, 941	194. 03
	07954 SCHOOL & TOWN CLINICS	1, 365, 023	479, 686			1, 814, 351	1
	07955 MANAGED FACILITY	0	440, 098			440, 084	1
	07956 RENTAL PROPERTIES	0	-14, 994			-14, 994	
		- 1					
	07957 SNF NON CERTIFIED	1, 009, 683	283, 256				
200.00	TOTAL (SUM OF LINES 118 through 199)	123, 208, 498	170, 958, 999	294, 167, 497	[] 0	294, 167, 497	J∠UU. UU

Health FinancialSystemsHENDRICKSRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0005

Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/30/2018 4:38 pm

				5/30/2018 4: 3	8 pm
	Cost Center Description	Adjustments	Net Expenses		
			or Allocation		
	T	6.00	7. 00		
	GENERAL SERVICE COST CENTERS	100 (00)	00.045.445		
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	-402, 602	22, 315, 465		1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-77, 551	5, 094, 824		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-15, 551, 135	34, 132, 700		5. 00
7. 00	00700 OPERATION OF PLANT	-162, 344	10, 451, 650		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	889, 454		8. 00
9.00	00900 HOUSEKEEPI NG	0	3, 588, 058		9. 00
10. 00	01000 DI ETARY	-463, 974	596, 854		10. 00
11. 00	01100 CAFETERI A	-920, 214	1, 754, 247		11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	-13, 688	3, 055, 119		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	-256	1, 438, 157		14. 00
15. 00	01500 PHARMACY	0	3, 702, 597		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	2, 420, 719		16. 00
17. 00	01700 SOCIAL SERVICE	-10, 081	2, 444, 423		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-3, 001, 937	14, 928, 497		30. 00
31.00	03100 INTENSIVE CARE UNIT	o	2, 346, 053		31.00
43.00	04300 NURSERY	ol	479, 672		43.00
44.00	04400 SKILLED NURSING FACILITY	ol	o		44.00
	ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	-1		
50.00	05000 OPERATI NG ROOM	0	9, 260, 407		50.00
50. 01	05001 ENDOSCOPY	o	1, 550, 656		50. 01
51. 00	05100 RECOVERY ROOM	l ol	1, 663, 586		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		997, 552		52. 00
53. 00	05300 ANESTHESI OLOGY	-5, 077, 549	1, 328, 786		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-75, 586	6, 756, 594		54.00
54. 00	05401 RADI ATI ON-ONCOLOGY	-33, 338	19, 985, 120		54. 00
56. 00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	-33, 336	413, 853		56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	794, 241		59.00
60.00	06000 LABORATORY	-818			60.00
			7, 971, 876		
64.00	06400 I NTRAVENOUS THERAPY	0	1, 417, 599		64. 00
65. 00	06500 RESPI RATORY THERAPY	0	2, 946, 758		65. 00
66. 00	06600 PHYSI CAL THERAPY	-596, 718	7, 232, 744		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	-38, 129	504, 501		67. 00
68. 00	06800 SPEECH PATHOLOGY	-3, 210	377, 503		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-178, 054	856, 285		69. 00
	06901 CARDI AC REHAB	0	622, 859		69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	130, 382		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	6, 071, 967		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11, 066, 216		73. 00
73. 01	07301 ULTRA SOUND	0	581, 005		73. 01
74.00	07400 RENAL DIALYSIS	0	191, 475		74.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	-40, 883	6, 031, 436		90. 00
91.00	09100 EMERGENCY	2, 538	6, 311, 927		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	SPECIAL PURPOSE COST CENTERS	·			
118.00		-26, 645, 529	204, 703, 817		118. 00
	NONREI MBURSABLE COST CENTERS				1
192 00	19200 PHYSI CI ANS' PRI VATE OFFI CES	n	49, 822, 016		192. 00
	19201 HEALTH TRACKS	l o	4, 095, 004		192. 01
	07950 PRIMARY CARE CLINIC		3, 347, 134		194. 00
	07951 PARTNERS IN CARE		887, 564		194. 00
	07951 PARTNERS TN CARE		908, 831		194. 01
	07953 FOUNDATION	0	230, 941		194. 03
	07954 SCHOOL & TOWN CLINICS	0	1, 814, 351		194. 04
	07955 MANAGED FACILITY	0	440, 084		194. 05
	07956 RENTAL PROPERTIES	0	-14, 994		194. 06
	07957 SNF NON CERTIFIED	0	1, 287, 220		194. 07
200.00	TOTAL (SUM OF LINES 118 through 199)	-26, 645, 529	267, 521, 968		200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/30/2018 4:38 pm Provider CCN: 15-0005

					5/30/2018	3 4:38 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	A - DRUG RECLASS					
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	,,		1. 00
2.00	INTRAVENOUS THERAPY	64.00	0			2. 00
3.00		0.00	0			3. 00
4.00		0.00	0			4. 00
5.00		0.00	0			5. 00
6. 00		0.00	0			6. 00
7.00		0.00	0			7. 00
8.00		0.00	0			8. 00
9.00		0.00	0			9. 00
10.00		0.00	0			10. 00
11. 00		0.00	0			11. 00
12.00		0.00	0			12.00
13.00		0.00	0			13.00
14. 00		0.00	0			14. 00
15. 00		0.00	0			15. 00
16. 00		0.00	0			16. 00
17. 00		0.00	0			17. 00
18. 00		0.00	0			18. 00
19. 00		0.00	0			19. 00
20.00		0.00	0			20.00
21. 00		0.00	0			21. 00
22. 00		0.00	0			22. 00
23. 00		0.00	0			23. 00
24.00		0.00	0			24. 00
25. 00		0.00	0			25. 00
26. 00		0.00	0			26. 00
27. 00		0.00	0	-		27. 00
28. 00		0.00	0			28. 00
	O NOR BLANE BEST ASS		0	11, 266, 078		
4 00	B - MOB PLANT RECLASS	4 00		(704		4 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0			1.00
2.00	ADMI NI STRATI VE & GENERAL	5. 00	0			2. 00
3.00	OPERATION OF PLANT	7.00	0			3. 00
4.00	LAUNDRY & LINEN SERVICE	8.00	0			4. 00
5.00	MEDI CAL RECORDS & LI BRARY	16.00	0	.,		5. 00
6.00	SOCI AL SERVI CE	17. 00	0			6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0			7. 00
8. 00	RADI ATI ON-ONCOLOGY	54. 01	0			8. 00
9.00	LABORATORY	60.00	0	-,		9.00
10.00	RESPIRATORY THERAPY	65.00	0	,		10.00
11. 00	PHYSI CAL THERAPY	66.00	0			11.00
12.00	OCCUPATIONAL THERAPY	67.00	0	,		12.00
13. 00	CLINIC	90.00	$\frac{0}{0}$			13. 00
	C - CAFETERIA RECLASS		0	007, 725		
1 00	CAFETERIA RECLASS	11. 00	1, 283, 712	1, 390, 749		1.00
1. 00						1.00
	D IMPLANTABLE DEVICES		1, 283, 712	1, 390, 749		
1. 00	D - IMPLANTABLE DEVICES IMPL. DEV. CHARGED TO	72.00	0	6, 071, 967		1.00
1.00	PATIENT	72.00	U	0, 0/1, 90/		1.00
2. 00	I ATTENT	0.00	0	0		2. 00
2.00		— — 	— — <u> </u>			2.00
	F - MEDICAL SUPPLY RECLASS		0	5, 5, 1, 7, 7, 7		
1. 00	OPERATING ROOM	50.00	0	3, 853, 632		1.00
2. 00	1	0.00	0			2. 00
3. 00		0.00	0			3. 00
4. 00		0.00	0			4. 00
5. 00		0.00	0			5. 00
6. 00		0.00	0			6. 00
7. 00		0.00	0			7. 00
8. 00		0.00	0			8. 00
9. 00		0.00	0			9. 00
10. 00		0.00	0			10.00
11. 00		0.00	0			11. 00
12. 00		0.00	0			12. 00
13. 00		0.00	0			13. 00
14. 00		0.00	0			14. 00
15. 00		0.00	0			15. 00
16. 00		0.00	0			16. 00
17. 00		0.00	0			17. 00
18. 00		0.00	0			18. 00
19. 00		0.00	0			19. 00
20. 00		0.00	0			20. 00
20.00	l .	0.00	0	ı U		1 20.00

Health Financial Systems RECLASSIFICATIONS HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 Provider CCN: 15-0005

					5/30/2018 4:38 pm	_
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4.00	5. 00		
21. 00		0.00	0	0	21.00	5
22.00		0.00	0	0	22. 00)
23.00		0.00	0	0	23.00)
24.00		0.00	0	0	24.00)
25.00		0.00	0	0	25. 00)
26.00		0.00	0	0	26. 00)
27.00		0.00	o	0	27. 00)
28. 00		0.00	o	0	28.00)
29.00		0.00	o	0	29.00)
30.00		0.00	o	0	30.00)
31.00		0.00	O	0	31.00)
32.00		0.00	O	0	32.00)
33.00		0.00	O	0	33.00)
34.00		0.00	O	0	34.00)
35.00		0.00	O	0	35.00)
36.00		0.00	O	0	36.00)
37.00		0.00	O	0	37.00)
38.00		0.00	O	0	38.00)
	0 — — — — — —			3, 853, 632		
	G - HIM RECLASS		·			
1.00	MEDICAL RECORDS & LIBRARY	16. 00	1, 119, 116	1, 299, 650	1.00)
	TOTALS		1, 119, 116	1, 299, 650		
500.00	Grand Total: Increases		2, 402, 828	24, 489, 801	500. 00)

Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/30/2018 4:38 pm

Cost Centure Cost							5/30/2018 4:3	38 pm
Color Colo			Decreases					
A - DRIGHT REPARTMENT A -		Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
DO DATES OF PARTICLES 1.00 0 2.97 0 1.00 3		6. 00	7. 00	8. 00	9. 00	10. 00		
2.00 APAIN INSTRATIVE A GAMERAU 5.00 0 31,875 0 2.00 4.00		A - DRUG RECLASS						
Description	1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	29	0		1.00
A	2.00	ADMINISTRATIVE & GENERAL	5.00	0	31, 875	0		2. 00
ADULTS & PEDIATRICS 30.00	3.00	DI ETARY	10.00	o	115	o		3.00
ADULTS & PEDIATRICS 30.00	4.00	PHARMACY	15. 00	O	8, 157, 242	o		4.00
A						o		1
1.00 DEFENTING ROYAL 1.00 1.0				-				1
8.00 SIF NON CERTIFIED 194.07 0 37 0 9.00 10.00 MECONERY NOOM 5.00 0 10.00 9.00 10.00 MECONERY NOOM 5.1.00 0 7.13 0 11.00 11.00 ALCONERY NOOM 5.1.00 0 7.13 0 11.00 12.00 ALCONERY NOOM 5.1.00 0 6.74 0 11.00 13.00 ARD ATTON-ONCOLOGY 5.0.01 0 6.74 0 12.00 15.00 ARD ATTON-ONCOLOGY 5.0.01 0 6.74 0 12.00 15.00 ARD ATTON-ONCOLOGY 6.0.00 0 6.00 0 13.0 15.00 ARD ATTON-ONCOLOGY 6.0.00 0 5.46 0 15.00 15.00 ARD ATTON-ONCOLOGY 6.0.00 0 5.46 0 15.00 15.00 ARD ATTON-ONCOLOGY 6.0.00 0 5.46 0 15.00 15.00 ARD ATTON-ONCOLOGY 6.0.00 0 6.0.00 6.0.00 15.00 ARD ATTON-ONCOLOGY 6.0.00 0 6.0.00 6.0.00 16.00 ARD ATTON-ONCOLOGY 6.0.00 6.0.00 6.0.00 6.0.00 6.0.00 16.00 ARD ATTON-ONCOLOGY 6.0.00						l .		1
9 - 00 DELINITING RODIN 90 - 00 10,099 0 10,099 0 10,000 11,000 10,000 11						I - I		1
10.00 RECOVERY ROOM & JANGER ROOM 51.00 0 713 0 10.00 10.00 10.00 11.00 11.10 11.10 11.10 11.10 ROOM & JANGER ROOM 52.00 0 1.257 0 11.00 11.00 11.10 11.00 11.10 ROOM & JANGER ROOM 12.00 12.00 12.00 12.00 11.00 12.00 12.00 11.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 15.00						1		1
11.00 BELLYERY ROOM & LASBOR ROOM 52.00 0 12.57 0 11.00 12.00				-				1
2.00 RADIOLOGY-DI AGMOSTIC 54.00 0 0.954 0 12.00 13.00 RADIA TAID -MODILOGY 5.4.01 0 134.00 13.00 13.00 RADIA TAID -MODILOGY 5.4.01 0 13.0		l .				l .		1
13.00 MOLITATION-DIOLOGY						l .		1
14.00 ABDRATORY 60.00 60 61.00 11.00 15.00 11.00 15.00 11.00 15.00 11.00 15.00 11.00 15.00 11.00 15.00 11.00 15.00 11.00 15.00 11.00 15.00 11.		l .		-				1
15.00 INTRAVENDUS THERAPY		l .				l .		1
16.00 RESPIRATORY HIERARY 65.00 0 636 0 16.00		l .		-		· ·		
17.00		l .				l .		1
18.00 LECTROCARDIOLOGY 69.00 0 165 0 119.00		l .		-		· ·		1
19.00 CARDIAC REHAB 09.01 0 328 0 20.00		1		-		l 1		1
20.00 REMAL DIALYSIS 74.00 0 8.228 0 22.00				- 1		l 1		1
21.00 CLINIC 90.00 0 8, 222 0 22.00 22.00 EMRRECROY PRIVATE OFFICES 192.00 0 2.864, 224 0 22.00 23.00 PHYSTICIANS' PRIVATE OFFICES 192.00 0 2.864, 224 0 22.00 24.00 HEACH TRACKS 19.00 0 13, 774 0 22.00 25.00 PRI MARY CARE CLINIC 194.00 0 13, 774 0 22.00 25.00 PRI MARY CARE CLINIC 194.00 0 13, 128 0 22.00 26.00 PARTHERES IN CARE 194.01 0 14, 781 0 22.00 27.00 DCCUPATI ORAL MEDI CINE 194.02 0 35, 883 0 27.00 27.00 DCCUPATI ORAL MEDI CINE 194.02 0 35, 883 0 27.00 27.00 DCCUPATI ORAL MEDI CINE 194.02 0 35, 883 0 27.00 27.00 DCCUPATI ORAL MEDI CINE 194.02 0 35, 883 0 27.00 28.00 SERVICE A TOWN CLINICS 194.02 0 36, 883 0 27.00 29.00 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l .		- 1		1		1
22 00 MCRCENCY				-		l .		1
23. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 2.8.64, 224 0 0 22. 00 25. 00 PRIMARY CARE CLINIC 194. 00 0 13, 128 0 25. 00 27. 00 OCCUPATIONAL MEDICINES 194. 01 0 14, 781 0 26. 00 27. 00 OCCUPATIONAL MEDICINES 194. 02 0 35. 883 0 27. 00 0CCUPATIONAL MEDICINES 194. 00 0 17, 265 0 0 22. 00 0CCUPATIONAL MEDICINES 194. 00 0 17, 265 0 0 22. 00 0CCUPATIONAL MEDICINES 194. 00 0 17, 265 0 0 22. 00 0CCUPATIONAL MEDICINES 194. 00 0 17, 265 0 0 22. 00 0CCUPATIONAL MEDICINES 194. 00 0 17, 265 0 0 22. 00 0CCUPATIONAL MEDICINES 194. 00 0 17, 265 0 0 22. 00 0CCUPATIONAL MEDICINES 194. 00 0 17, 265 0 0 17, 265 0 0 22. 00 0CCUPATIONAL MEDICINES 194. 00 0 17, 265 0 0 1 1, 265 0 0 2 2. 00 0CCUPATIONAL MEDICINES 194. 00 0 17, 265 0 0 1 1, 265 0 0 2 2. 00 0CCUPATIONAL MEDICINES 194. 00 0 17, 265 0 0 1 1, 265 0 0 2 2. 00 0CCUPATIONAL MEDICINES 194. 00 0 17, 265 0 0 1 1, 265 0 0 2 2. 00 0CCUPATIONAL MEDICINES 194. 00 0 1 1, 265 0 0 2 2. 00 0CCUPATIONAL MEDICINES 194. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1		0	8, 222	· ·		
24.00	22.00		91. 00	0	1, 261	0		22. 00
24.00	23.00	PHYSICIANS' PRIVATE OFFICES	192. 00	o	2, 864, 224	o		23. 00
26. 00 PARTNERS IN CARE	24.00	HEALTH TRACKS	192. 01	0	37, 774	o		24. 00
26. 00 PARTNERS IN CARE	25. 00	PRIMARY CARE CLINIC		o				25. 00
27.00	26.00	PARTNERS IN CARE	194. 01	o	14, 781	ol		26.00
28. 00		1		-		l .		
1.00				-				1
1.00	20.00							20.00
1.00				<u> </u>	11, 200, 070			1
2.00 0.00 0.00 0 0 0 2.00 4.00 0.00 0.00 0 0 0 0 5.00 0.00 0.00 0 0 0 6.00 0.00 0.00 0 0 0 7.00 0.00 0.00 0 0 0 8.00 0.00 0.00 0 0 0 8.00 0.00 0.00 0 0 0 8.00 0.00 0.00 0 0 0 9.00 0.00 0 0 0 11.00 0.00 0 0 0 12.00 0.00 0 0 0 13.00 0.00 0 0 0 13.00 0.00 0 0 0 13.00 0.00 0 0 0 13.00 0.00 0 0 0 13.00 0.00 0 0 0 14.00 0.00 0 0 0 15.00 0.00 0 0 0 16.00 0.00 0 0 0 17.00 0.00 0 0 0 18.00 0.00 0 0 0 19.00 0 0 0 11.00 0 0 0 0 11.00 0 0 0 0 12.00 0 0 0 0 13.00 0 0 0 0 14.00 0 0 0 15.00 0 0 0 16.00 0 0 0 17.00 0 0 0 18.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 1	1 00		102 00	n	607 725	n		1 100
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7. 00 8. 00 9. 00					0	· ·		
8. 00 9. 00 9. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 12. 00 12. 00 13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0	· ·		1
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10.00					0	l .		1
11.00				~	0	I - I		1
12.00				~	0	· · · · · · · · · · · · · · · · · · ·		1
13.00				0	0	0		1
1.00 DIETARY 10.00 1,283,712 1,390,749 0 1.00 1,283,712 1,390,749 0 1.00 1,283,712 1,390,749 0 1.00 1,283,712 1,390,749 0 1.00 0 1,283,712 1,390,749 0 1.00 0 1,283,712 1,390,749 0 1.00 0 1,283,712 1,390,749 0 1.00 0 1,283,712 1,390,749 0 1.00 0 1,283,712 1,390,749 0 1.00 0 1,283,712 1,390,749 0 1.00 0 1,283,712 1,390,749 0 1.00 0 1,000	12.00		0.00	0	0	0		12. 00
C - CAFETERIA RECLASS DIETARY	13.00		0.00	0	0	0		13. 00
1.00		0 — — — — — —			607, 725			
D		C - CAFETERIA RECLASS						1
D	1.00	DI ETARY	10.00	1, 283, 712	1, 390, 749	0		1.00
1.00 OPERATING ROOM So. 00 O S, 522, 741 O S49, 226 O O S49, 226 O O O O O O O O O								
1.00 OPERATING ROOM So. 00 O S, 522, 741 O S49, 226 O O S49, 226 O O O O O O O O O			<u> </u>	,,	,			1
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The following content of the conte								
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1.00 EMPLOYEE BENEFITS DEPARTMENT		O			3, 3, 1, 707			1
2. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 339 0 2. 00 3. 00 LAUNDRY & LI NEN SERVI CE 8. 00 0 136 0 3. 00 4. 00 HOUSEKEEPI NG 9. 00 0 133 0 4. 00 5. 00 DI ETARY 10. 00 0 339 0 5. 00 6. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 539 0 6. 00 7. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 5. 046 0 7. 00 8. 00 PHARMACY 15. 00 0 82, 147 0 8. 00 9. 00 ADULTS & PEDI ATRI CS 30. 00 0 366, 990 0 9. 00 10. 00 I NTENSI VE CARE UNI T 31. 00 0 127, 291 0 10. 00 11. 00 NURSERY 43. 00 0 56, 924 0 11. 00 12. 00 SNF NON CERTI FI ED 194. 07 0 5, 682 0 12. 00 13. 00 ENDOSCOPY 50. 01 0 301, 458 0 13. 00 15. 00 DELI VERY ROOM 51. 00 0 98, 472 0 15. 00 15. 00 DELI VERY ROOM LABOR ROOM 52. 00 0 39, 239 0 15. 00 16. 00 ANESTHESI OLOGY 53. 00 168, 349 0 16. 00 17. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 406, 207 0 17. 00 19. 00 NUCLEAR MEDI CI NE - 56. 00 0 1, 362 0 19. 00 19. 00 NUCLEAR MEDI CI NE - 56. 00 0 1, 362 0 19. 00 19. 00 NUCLEAR MEDI CI NE - 56. 00 0 1, 362 0 0 19. 00 19. 00 NUCLEAR MEDI CI NE - 56. 00 0 1, 362 0 0 19. 00 19. 00 NUCLEAR MEDI CI NE - 56. 00 0 1, 362 0 0 19. 00 10. 00 TI TABOR SERVICES & SUPPLY ACCURATE TO THE CONTROL OF	1 00		4 00	ما	1 625	٥		1 00
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18. 00 RADI ATI ON-ONCOLOGY 54. 01 0 22, 426 0 18. 00 19. 00 NUCLEAR MEDI CI NE - 56. 00 0 1, 362 0 19. 00				o		l 1		1
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		1. Zimerem emilion	07.00	<u> </u>	.07, 102	, <u> </u>		

Health Financial Systems RECLASSIFICATIONS HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 Provider CCN: 15-0005

						5/30/2018 4:38 pm
		Decreases				
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7. 00	8.00	9. 00	10. 00	
21.00	LABORATORY	60.00	0	2, 030	C	21. 00
22.00	I NTRAVENOUS THERAPY	64. 00	0	64, 960	C	22. 00
23.00	RESPIRATORY THERAPY	65. 00	0	83, 951	C	23. 00
24.00	PHYSI CAL THERAPY	66.00	0	90, 168	C	24. 00
25.00	OCCUPATI ONAL THERAPY	67. 00	0	3, 285	C	25. 00
26.00	ELECTROCARDI OLOGY	69. 00	0	4, 682	C	26. 00
27.00	CARDI AC REHAB	69. 01	0	4, 413	C	27. 00
28.00	ELECTROENCEPHALOGRAPHY	70.00	0	38	C	28. 00
29.00	ULTRA SOUND	73. 01	0	65, 725	C	29. 00
30.00	CLINIC	90.00	0	349	C	30.00
31.00	EMERGENCY	91. 00	0	359, 377	C	31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	1, 025, 190	C	32.00
33.00	HEALTH TRACKS	192. 01	0	35, 921	C	33.00
34.00	PRIMARY CARE CLINIC	194. 00	0	1, 819	C	34.00
35.00	PARTNERS IN CARE	194. 01	0	9, 164	C	35. 00
36.00	OCCUPATIONAL MEDICINE	194. 02	0	7, 605	C	36.00
37.00	SCHOOL & TOWN CLINICS	194. 04	0	875	C	37.00
38.00	MANAGED FACILITY	194. 05	0	14	C	38.00
	0 — — — — — —			3, 853, 632		
	G - HIM RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5. 00	1, 119, 116	1, 299, 650	C	1.00
	TOTALS		1, 119, 116	1, 299, 650		
500.00	Grand Total: Decreases		2, 402, 828	24, 489, 801		500.00

					То	12/31/2017	Date/Time Pre 5/30/2018 4:3	pared: 8 pm
				Acqui si ti ons				
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2. 00	3.00		4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	28, 602, 369	0		0	0	0	1. 00
2.00	Land Improvements	16, 423, 618	0		0	0	0	2. 00
3.00	Buildings and Fixtures	240, 688, 423	0		0	0	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	162, 139, 929	0		0	0	0	6. 00
7.00	HIT designated Assets	0	0		0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	447, 854, 339	0		0	0	0	8. 00
9.00	Reconciling Items	0	0		0	0	0	9. 00
10. 00	Total (line 8 minus line 9)	447, 854, 339	0		0	0	0	10. 00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
	DART 1 ANALYSIS OF SUMMORS IN SARITAL ASSET	6.00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	28, 602, 369	0					1. 00
2.00	Land Improvements	16, 423, 618	0					2. 00
3.00	Buildings and Fixtures	240, 688, 423	0					3. 00
4.00	Building Improvements	0	0					4. 00
5.00	Fi xed Equi pment	0	0					5. 00
6.00	Movable Equipment	162, 139, 929	0					6. 00
7.00	HIT designated Assets	0	0					7. 00
8.00	Subtotal (sum of lines 1-7)	447, 854, 339	0					8. 00
9.00	Reconciling Items	0	0					9. 00
10. 00	Total (line 8 minus line 9)	447, 854, 339	O					10. 00

Heal th	Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lieu of Form CMS-2552-10			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Peri od:	Worksheet A-7		
					From 01/01/2017 Fo 12/31/2017		narod:	
					10 12/31/2017	5/30/2018 4:3		
			SU	IMMARY OF CAPI	TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see			
					instructions)	instructions)		
		9. 00	10. 00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	17, 712, 873	0	5, 005, 19	4 0	0	1. 00	
3.00	Total (sum of lines 1-2)	17, 712, 873	0	5, 005, 19	4 0	0	3. 00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum					
		Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	22, 718, 067				1.00	
3.00	Total (sum of lines 1-2)	0	22, 718, 067				3. 00	
							•	

Health Financial Systems	HENDRI CKS REG	ONAL HEALTH		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		eri od:	Worksheet A-7	
				rom 01/01/2017 o 12/31/2017	Part III Date/Time Prep	pared:
					5/30/2018 4: 38	
	СОМІ	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi talized	Gross Assets	Ratio (see	Insurance	
· ·		Leases	for Ratio	instructions)		
			(col. 1 - col.			
			2)			
	1.00	2. 00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL						
1.00 NEW CAP REL COSTS-BLDG & FIXT	447, 854, 339	l e	447, 854, 339		0	1. 00
3.00 Total (sum of lines 1-2)	447, 854, 339		447, 854, 339			3. 00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
	(00	d Costs 7.00	through 7)	9, 00	10.00	
PART III - RECONCILIATION OF CAPITAL	6. 00	7.00	8. 00	9.00	10. 00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	COSTS CENTERS			17, 702, 144	0	1. 00
3.00 Total (sum of lines 1-2)		0		17, 702, 144		3. 00
3.00 Total (Suil Of Titles 1-2)	0	<u> </u>	JMMARY OF CAPIT		U	3.00
		30	JIVIIVIAKT OF CAFT	AL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL			1			
1.00 NEW CAP REL COSTS-BLDG & FIXT	4, 613, 321	0	1	_	22, 315, 465	1. 00
3.00 Total (sum of lines 1-2)	4, 613, 321	0	(C	0	22, 315, 465	3. 00

					From 01/01/2017 Fo 12/31/2017		
				Expense Classification on	Worksheet A	5/30/2018 4: 3	3 pm
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1. 00 B	2.00	3.00 NEW CAP REL COSTS-BLDG &	4. 00	5. 00	1. 00
1.00	REL COSTS-BLDG & FIXT (chapter		-14, 725	FIXT	1.00	''	1.00
2. 00	2) Investment income - CAP REL		0	*** Cost Center Deleted ***	2.00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	A	-377, 148	NEW CAP REL COSTS-BLDG &	1.00	11	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0	FI XT	0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	O	7. 00
8. 00	21) 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 -8, 886, 362		0.00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00		
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-920, 214 0	CAFETERI A	11. 00	0	14. 00 15. 00
16. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	O	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	1	20. 00 21. 00
21.00	interest, finance or penalty charges (chapter 21)		J		0.00		21.00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114.00		25. 00
26. 00	physicians' compensation (chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26. 00
	COSTS-BLDG & FLXT			FIXT			
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	1	28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	1	29. 00 30. 00
55. 60	therapy costs in excess of		O	SSSSIALI SIME ILEMAI I	07.00		55.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest	1					

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 15-0005

				To	12/31/2017	Date/Time Prep 5/30/2018 4:38	
				Expense Classification on	Worksheet A	3/30/2018 4.30	o piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
33. 00	1993 CARRYFORWARD	A	-14, 017	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 00
33. 01	1994 CARRYFORWARD	A	3 288	FIXT NEW CAP REL COSTS-BLDG &	1.00	9	33. 01
33.01	1774 CARRITORWARD	^		FIXT	1.00	7	33.01
33.06	ADMITTING TELEPHONE	А		ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
	(EQUI PMENT)						
33. 07	ADMITTING TELEPHONE (SALARY)	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 08	MARKETING DEPARTMENT	A		ADMINISTRATIVE & GENERAL	5. 00	l	
33. 09	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00	l	33. 09
33. 10	I HA LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	1	
33. 11	AHA LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	
34. 00	HOSPITAL ASSESSMENT FEE	A		ADMINISTRATIVE & GENERAL	5. 00		34.00
35. 00	MEALS ON WHEELS	A	-448, 516		10.00		
36. 00	HUMAN RESOURCES JURY DUTY	В	-77	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	36. 00
37. 00	RECEIPTS HRH WELLNESS ED DEPARTMENT	В	-77, 474	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37. 00
38. 00	COURSES INVESTMENT	В	252, 735	ADMINISTRATIVE & GENERAL	5. 00	0	38. 00
39. 00	GAIN/LOSS-ADMINISTRATION REVENUE - OTHER	В	-1, 419	ADMINISTRATIVE & GENERAL	5. 00	0	39. 00
40. 00	NON-OPERATI NG-CHAPLA REVENUE - OTHER	В	-5, 000	ADMINISTRATIVE & GENERAL	5. 00	0	40. 00
41. 00	NON-OPERATI NG-REVENU REVENUE - OTHER	В	-29	ADMINISTRATIVE & GENERAL	5. 00	0	41. 00
43. 00	OPERATING-ADMINISTRA REVENUE - OTHER	В	163	ADMINISTRATIVE & GENERAL	5. 00	0	43. 00
44. 00	OPERATING-FINANCIAL REVENUE - OTHER OPERATING-GIFT	В	-307, 037	ADMINISTRATIVE & GENERAL	5. 00	0	44. 00
45. 00	SHOP REVENUE - OTHER	В	-80	ADMINISTRATIVE & GENERAL	5. 00	0	45. 00
45. 01	OPERATI NG-OPERATI ONA REVENUE - OTHER	В	-3, 718	ADMINISTRATIVE & GENERAL	5. 00	0	45. 01
45. 02	OPERATI NG-REVENUE CY REVENUE - OTHER	В	-11, 426	ADMINISTRATIVE & GENERAL	5. 00	0	45. 02
45. 03	OPERATI NG-VOLUNTEER REVENUE - OTHER	В	-511, 340	ADMINISTRATIVE & GENERAL	5. 00	0	45. 03
45. 04	NON-OPERATING-HOSPIT REVENUE - OTHER OPERATING	В	-1. 955. 951	ADMINISTRATIVE & GENERAL	5. 00	0	45. 04
45. 05	REVENUE - OTHER OPERATING-HOSPITAL O	В		ADMINISTRATIVE & GENERAL	5. 00		45. 05
45. 06	TRIMEDX MISC	В	-80, 846	OPERATION OF PLANT	7. 00	0	45. 06
45. 07	REVENUE - OTHER OPERATING-ENGINEERIN	В	-81, 498	OPERATION OF PLANT	7. 00	0	45. 07
45. 08	REVENUE- OUTPATIENT- NUTRITION & DIE	В	-15, 458	DI ETARY	10.00	0	45. 08
45. 09	STAFF EDUCATION ED DEPT COURSES	В	-13, 336	NURSING ADMINISTRATION	13. 00	0	45. 09
45. 10	I NPATIENT - NURSI NG ADMI NI STRATI ON	В	-352	NURSING ADMINISTRATION	13. 00	0	45. 10
45. 11	MATERIALS MGMT. SUPPLIES SOLD TO OTH	В	-256	CENTRAL SERVICES & SUPPLY	14. 00	0	45. 11
45. 12	REVENUE - OTHER OPERATING-TRANSITION	В	-10, 081	SOCIAL SERVICE	17. 00	0	45. 12
45. 13	CBC - OB UNIT ED DEPT COURSES	В	_A 671	ADULTS & PEDIATRICS	30.00	0	45. 13
45. 15	RADI OLOGY SALE OF X-RAYS	В		RADI OLOGY-DI AGNOSTI C	54.00		1
45. 16	RAD ONCOLOGY SALE OF X-RAYS	В		RADI ATI ON-ONCOLOGY	54. 00 54. 01	0	1
	LABORATORY MISC. SERVICES	В		LABORATORY	60.00	-	1
45. 17		1					•
45. 18	REVENUE - OTHER OPERATING-HRH SPORTS	В	-483	PHYSICAL THERAPY	66. 00	0	45. 18
45. 19	REVENUE - OTHER OPERATI NG-PHYSI CAL T	В	-3, 079	PHYSI CAL THERAPY	66.00	0	45. 19
45. 20	REVENUE - OTHER OPERATI NG-PHYSI CAL T	В	-4, 408	PHYSI CAL THERAPY	66.00	0	45. 20
45. 21	REVENUE - OTHER OPERATI NG-PHYSI CAL T	В	-212	PHYSI CAL THERAPY	66.00	9	45. 21
45. 22	REVENUE - OTHER OPERATI NG-PHYSI CAL T	В	-5, 380	PHYSI CAL THERAPY	66.00	0	45. 22
45. 23	REVENUE - OTHER OPERATING-SPORTS MED	В	-24, 270	PHYSI CAL THERAPY	66.00	0	45. 23
45. 24	OCC THER ED DEPT CO	В		OCCUPATI ONAL THERAPY	67. 00		45. 24
45. 25	SPEECH THERAPY MISC	В	-3, 210	SPEECH PATHOLOGY	68. 00	0	45. 25

Hea	Ith Financial Systems		HENDRI CKS REG	IONAL HEALTH	In Lieu of Form CMS-2552-10					
ADJ	USTMENTS TO EXPENSES				Peri od:	Worksheet A-8				
					From 01/01/2017					
					To 12/31/2017					
				Fynanca Classification or	- Wardrahaat A	5/30/2018 4: 3	5 pili			
				Expense Classification or						
				To/From Which the Amount is	to be Adjusted					
	0 1 0 1 0 1 1	D : (0 (0)		2 1 2 1	1.1.11	W . A 7 D C				
	Cost Center Description			Cost Center		Wkst. A-7 Ref.				
		1.00	2. 00	3. 00	4. 00	5. 00				
45.	26 HI BBELN SUR CNT MI SCELLANEOUS	В	-40, 883	CLINIC	90.00	0	45. 26			
45.	27 REVENUE - OTHER	В	52, 969	EMERGENCY	91.00	0	45. 27			
	OPERATI NG-EMERGENCY						ł			
45.	28 EMS PROGRAM ED DEPT COURSES	В	-50, 427	EMERGENCY	91.00	0	45. 28			
50.	00 TOTAL (sum of lines 1 thru 49)		-26, 645, 529				50.00			
	(Transfer to Worksheet A,						1			
	column 6, line 200.)						1			
(1)	Description - all chapter referen	ces in this col	lumn pertain to	CMS Pub 15-1	<u>'</u>					
 Description - all chapter references in this column pertain to CMS Pub. 15-1. Basis for adjustment (see instructions). 										
A. Costs - if cost, including applicable overhead, can be determined.										
B. Amount Received - if cost cannot be determined.										
	B. Admitting received - II COSt Caminot be determined. 2) Additional adjustments may be made on lines 23 thru 40 and subscripts thereof									

- (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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

						0 12/31/201/	5/30/2018 4: 3	
	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		ADULTS & PEDIATRICS	2, 746, 846				0	1. 00
2.00		ADULTS & PEDIATRICS	249, 000			0	0	2. 00
3.00		EMERGENCY	540, 649			206, 300	5, 451	3. 00
4.00	0.00	EMEDOENOV	004 070	0	_	0	0 220	4. 00
5.00		EMERGENCY	231, 870			206, 300	2, 338	5. 00
6.00		RADI ATI ON-ONCOLOGY	2, 975			253. 900	1 125	6. 00 7. 00
7. 00 8. 00		LABORATORY RADI OLOGY-DI AGNOSTI C	137, 368 58, 866		,		1, 125 462	7. 00 8. 00
9. 00		PHYSI CAL THERAPY	558, 386	1	58, 866 0	265, 200 206, 300	462	9. 00
10. 00		RADI OLOGY-DI AGNOSTI C	63, 555			200, 300	0	10. 00
11. 00		ELECTROCARDI OLOGY	178, 054			206, 300	0	11. 00
12. 00		ADULTS & PEDIATRICS	3, 011			165, 500	20	
13. 00		PHYSI CAL THERAPY	500	1		0	0	13. 00
14. 00	54 00	RADI OLOGY-DI AGNOSTI C	8, 031		0	206, 300	Ö	14. 00
15. 00		ANESTHESI OLOGY	5, 120, 545		43, 000	233, 500	383	15. 00
200.00			9, 899, 656					200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
1 00	1. 00	2.00	8. 00	9.00	12. 00	13. 00	14. 00	1 00
1.00		ADULTS & PEDIATRICS		0	_		0	1.00
2. 00 3. 00		ADULTS & PEDIATRICS EMERGENCY	540, 645	0 27, 032			0	2. 00 3. 00
4.00	0.00		340, 643	27,032	0	0	0	4. 00
5. 00		EMERGENCY	231, 889	11, 594	_	0	0	5. 00
6. 00		RADI ATI ON-ONCOLOGY	231,007	11, 374	0	0	0	6. 00
7. 00		LABORATORY	137, 326	6, 866	_	0	Ö	7. 00
8. 00		RADI OLOGY-DI AGNOSTI C	58, 905			0	o	8. 00
9. 00		PHYSI CAL THERAPY	0	0	0	0	0	9. 00
10. 00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	10.00
11. 00	69. 00	ELECTROCARDI OLOGY	0	0	0	0	0	11. 00
12. 00	30. 00	ADULTS & PEDIATRICS	1, 591	80	0	0	0	12.00
13. 00	66. 00	PHYSI CAL THERAPY	0	0	0	0	0	13.00
14. 00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	14.00
15. 00	53. 00	ANESTHESI OLOGY	42, 996			0	0	15. 00
200.00			1, 013, 352			0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	0					1. 00
2.00	30. 00	ADULTS & PEDIATRICS	0	0	0	249, 000		2. 00
3.00	91. 00	EMERGENCY	0	540, 645	4	4		3.00
4.00	0. 00		0	0	_	0		4. 00
5. 00		EMERGENCY	0	201,007	0			5. 00
6. 00		RADI ATI ON-ONCOLOGY	0	1				6. 00
7. 00		LABORATORY	0			42		7. 00
8. 00		RADI OLOGY-DI AGNOSTI C	0			0		8. 00
9.00		PHYSI CAL THERAPY	0		0	558, 386		9. 00
10.00		RADI OLOGY - DI AGNOSTI C	0			63, 555		10.00
11. 00		ELECTROCARDI OLOGY	0			178, 054		11. 00
12.00		ADULTS & PEDIATRICS	0		1, 420	1, 420		12.00
13. 00 14. 00		PHYSI CAL THERAPY RADI OLOGY-DI AGNOSTI C	0	_	0	500 8, 031		13. 00 14. 00
15. 00		ANESTHESI OLOGY				5, 077, 549		15. 00
200.00	55.00	ANESTHESI GEOGI						200. 00
200.00		l	1	1,013,332	1,470	0,000,302		200.00

In Lieu of Form CMS-2552-10
Worksheet B
Part I
B1/2017 Date/Time Prepared:
5/30/2018 4:38 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS HENDRICKS REGIONAL HEALTH Provider CCN: 15-0005 Peri od: From 01/01/2017 To 12/31/2017 CAPITAL RELATED COSTS

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		0	1.00	4. 00	4A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	22, 315, 465		E 200 44E			1.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	5, 094, 824 34, 132, 700		5, 289, 445 675, 467	36, 279, 685	36, 279, 685	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	10, 451, 650		112, 359	12, 810, 984	2, 009, 787	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	889, 454		15, 076	1, 181, 371	185, 333	8. 00
9.00	00900 HOUSEKEEPI NG	3, 588, 058			3, 805, 423	l	9. 00
10.00	01000 DI ETARY	596, 854		22, 142	1, 106, 553		10. 00
11.00	01100 CAFETERI A	1, 754, 247			1, 896, 631	297, 543	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	3, 055, 119		· ·	3, 399, 864	533, 371	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	1, 438, 157 3, 702, 597		34, 151 90, 960	1, 923, 222 3, 992, 544	301, 715 626, 350	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 420, 719			2, 678, 855	l	16. 00
17. 00	01700 SOCIAL SERVICE	2, 444, 423			2, 614, 784	l	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	14, 928, 497			17, 539, 218		30. 00
31.00	03100 I NTENSI VE CARE UNI T	2, 346, 053			2, 675, 772		31.00
43.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	479, 672 0		16, 764 0	544, 982	85, 497 0	43.00
44. 00	ANCI LLARY SERVICE COST CENTERS	0	0	U U	0	0	44. 00
50. 00	05000 OPERATI NG ROOM	9, 260, 407	484, 413	103, 914	9, 848, 734	1, 545, 069	50. 00
50. 01	05001 ENDOSCOPY	1, 550, 656			1, 753, 559		50. 01
51.00	05100 RECOVERY ROOM	1, 663, 586	797, 780	55, 693	2, 517, 059	394, 876	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	997, 552			1, 199, 389		52. 00
53.00	05300 ANESTHESI OLOGY	1, 328, 786		230, 263	1, 559, 049		53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C 05401 RADI ATI ON - ONCOLOGY	6, 756, 594		183, 657 52, 788	7, 826, 363		54. 00 54. 01
54. 01 56. 00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	19, 985, 120 413, 853			20, 610, 944 436, 269		56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	794, 241	277, 452		1, 097, 410		59. 00
60.00	06000 LABORATORY	7, 971, 876			8, 392, 515	1	60.00
64.00	06400 I NTRAVENOUS THERAPY	1, 417, 599			1, 497, 645		64. 00
65. 00	06500 RESPI RATORY THERAPY	2, 946, 758	334, 817	86, 572	3, 368, 147	528, 395	65. 00
66. 00	06600 PHYSI CAL THERAPY	7, 232, 744			7, 975, 394		66. 00
67. 00	06700 OCCUPATIONAL THERAPY	504, 501			574, 860		67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	377, 503 856, 285		11, 718 24, 246	458, 344 1, 002, 362	l	68. 00 69. 00
69. 01	06901 CARDI AC REHAB	622, 859		19, 586	785, 056		69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	130, 382			212, 634	33, 358	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	6, 071, 967		0	6, 071, 967	952, 570	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	11, 066, 216		0	11, 066, 216		73. 00
73. 01	07301 ULTRA SOUND 07400 RENAL DI ALYSI S	581, 005			621, 026	1	73. 01
74. 00	OUTPATIENT SERVICE COST CENTERS	191, 475	U	0	191, 475	30, 039	74. 00
90. 00	09000 CLINI C	6, 031, 436	586, 861	73, 425	6, 691, 722	1, 049, 797	90. 00
	09100 EMERGENCY	6, 311, 927		· ·	7, 136, 095		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
440.00	SPECIAL PURPOSE COST CENTERS	004 700 047	44 704 000	0 540 047	405 044 400	04.054.004	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	204, 703, 817	14, 731, 998	3, 513, 217	195, 344, 122	24, 954, 031	118.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	49, 822, 016	6, 190, 037	1, 449, 428	57, 461, 481	9, 014, 599	192. 00
	19201 HEALTH TRACKS	4, 095, 004			4, 586, 144		
194.00	07950 PRIMARY CARE CLINIC	3, 347, 134			3, 719, 262		
	07951 PARTNERS IN CARE	887, 564			1, 053, 747	165, 312	
	07952 OCCUPATI ONAL MEDI CI NE	908, 831		11, 111	1, 057, 693		
	307953 FOUNDATION	230, 941		6, 469	251, 467	39, 450	
	07954 SCHOOL & TOWN CLINICS 07955 MANAGED FACILITY	1, 814, 351 440, 084		59, 332 0	1, 907, 095 440, 084		
	07956 RENTAL PROPERTIES	-14, 994		0	-14, 994		194. 05
	07957 SNF NON CERTIFIED	1, 287, 220		_	1, 715, 867	269, 185	
200.00	1 1				0	1	200. 00
201.00			0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	267, 521, 968	22, 315, 465	5, 289, 445	267, 521, 968	36, 279, 685	202. 00

				10	0 12/31/201/	5/30/2018 4:3	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	, p
	·	PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
	IERAL SERVI CE COST CENTERS	1		1			
	100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	500 ADMINISTRATIVE & GENERAL	14 000 771					5. 00
	700 OPERATION OF PLANT	14, 820, 771	1 2// 704				7. 00
	BOO LAUNDRY & LINEN SERVICE	204 003	1, 366, 704				8.00
	POO HOUSEKEEPI NG DOO DI ETARY	206, 983 812, 033	0	.,,	2 247 447		9. 00
	100 CAFETERI A	144, 210	0	155, 465	2, 247, 647	2, 338, 384	
	BOO NURSI NG ADMI NI STRATI ON	419, 735	0	36, 099	0	2, 336, 364 83, 806	
	100 CENTRAL SERVICES & SUPPLY	751, 005	422		0	55, 627	
	500 PHARMACY	331, 415	1, 780		0	76, 609	1
	500 MEDICAL RECORDS & LIBRARY	263, 116	1, 700		0	74, 050	
	700 SOCIAL SERVICE	203, 110	0		0	80, 182	
	PATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		0, 120	<u> </u>	00, 102	17.00
	000 ADULTS & PEDIATRICS	3, 411, 247	367, 229	1, 836, 337	1, 710, 555	469, 581	30.00
	100 INTENSIVE CARE UNIT	427, 103	51, 279		216, 657	74, 343	31.00
	BOO NURSERY	80, 854	19, 461	14, 492	320, 435	12, 718	
44. 00 044	400 SKILLED NURSING FACILITY	O	0	0	0	0	44. 00
ANC	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	806, 798	91, 400		0	97, 282	50. 00
	DO1 ENDOSCOPY	260, 983	50, 248		0	47, 783	
	100 RECOVERY ROOM	1, 328, 716	101, 974		0	62, 244	
	200 DELIVERY ROOM & LABOR ROOM	274, 216	71, 781	6, 851	0	30, 937	
	BOO ANESTHESI OLOGY	0	0	7, 378	0	53, 343	
	100 RADI OLOGY-DI AGNOSTI C	843, 493	150, 925		0	194, 350	
	401 RADI ATI ON-ONCOLOGY	0	9, 426		0	61, 450	
	450 NUCLEAR MEDICINE - DIAGNOSTIC	25, 546	0		0	5, 794	
	900 CARDI AC CATHETERI ZATI ON	462, 101	0	,	0	21, 916	
	DOO LABORATORY 400 I NTRAVENOUS THERAPY	437, 331	164 5, 528		0	153, 419 31, 851	1
	500 RESPIRATORY THERAPY	65, 682 497, 244	5, 528	16, 600	0	100, 377	1
	500 PHYSI CAL THERAPY	340, 722	92, 893		0	223, 505	
	700 OCCUPATI ONAL THERAPY	20, 989	72, 673		0	14, 699	
	BOO SPEECH PATHOLOGY	115, 125	0	7, 905	0	8, 959	
	900 ELECTROCARDI OLOGY	202, 911	21, 986		0	52, 706	
	PO1 CARDI AC REHAB	143, 289	477		0	18, 044	1
	000 ELECTROENCEPHALOGRAPHY	130, 007	1, 151		0	8, 671	1
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72. 00 072	200 IMPL. DEV. CHARGED TO PATIENT	0	0	o	0	0	72. 00
73. 00 073	BOO DRUGS CHARGED TO PATIENTS	O	0	0	0	0	73. 00
73. 01 073	BO1 ULTRA SOUND	33, 059	0	8, 959	0	18, 794	73. 01
74.00 074	400 RENAL DIALYSIS	0	168	12, 384	0	0	74. 00
	TPATIENT SERVICE COST CENTERS						
	DOO CLI NI C	0	88, 400	1	0	0	
	100 EMERGENCY	1, 096, 187	177, 499	332, 273	0	165, 103	
	200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	CLIAL PURPOSE COST CENTERS	12 022 100	1 204 101	4 0(0 700	2 247 447	2 200 142	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	13, 932, 100	1, 304, 191	4, 068, 702	2, 247, 647	2, 298, 143	1118.00
	200 PHYSI CLANS' PRI VATE OFFI CES	55, 357	38, 271	322, 260	٥	0	192. 00
	201 HEALTH TRACKS	05, 357	8, 078		0		192. 00
	950 PRIMARY CARE CLINIC	0	684		0		194. 00
	951 PARTNERS IN CARE	192, 490	890		0		194. 01
	952 OCCUPATIONAL MEDICINE	0	2, 406		0		194. 02
	953 FOUNDATION	l o	2, 100	1, 844	0		194. 03
	954 SCHOOL & TOWN CLINICS	0	503		0		194. 04
	955 MANAGED FACILITY	0	0	0	ol		194. 05
	956 RENTAL PROPERTIES		O	O	o		194. 06
	957 SNF NON CERTIFIED	640, 824	11, 681	0	o	40, 241	194. 07
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	o	0	o	o		201. 00
202. 00	TOTAL (sum lines 118 through 201)	14, 820, 771	1, 366, 704	4, 609, 401	2, 247, 647	2, 338, 384	202. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | Part | |

			To	12/31/2017	Date/Time Pre 5/30/2018 4:3	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	O PIII
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
	12.00	SUPPLY	15.00	LI BRARY	17.00	
GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10. 00
11. 00 01100 CAFETERI A						11. 00
13.00 O1300 NURSING ADMINISTRATION	4, 472, 875					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	3, 120, 263				14. 00
15. 00 01500 PHARMACY	0	0	5, 049, 251	0 474 754		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	3, 474, 751	2 100 500	16.00
17. 00 O1700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	U	U	0	3, 108, 598	17. 00
30. 00 03000 ADULTS & PEDI ATRI CS	1, 457, 616	0	0	396, 688	2, 209, 609	30.00
31. 00 03100 NTENSI VE CARE UNI T	230, 765	0	0	89, 767	239, 063	31.00
43. 00 04300 NURSERY	39, 477	0	0	0,7,707	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	301, 972	3, 120, 263	0	0	0	50. 00
50. 01 05001 ENDOSCOPY	148, 321	0	0	0	0	50. 01
51.00 05100 RECOVERY ROOM	193, 210	0	0	153, 393	0	51. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	96, 030	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	165, 580	0	0	0	0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 54. 01 05401 RADI ATI ON - ONCOLOGY	603, 279	0	0	336, 780	0	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY 56. 00 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C	0	0	0	0	0	54. 01 56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	68, 029	0	0	0	0	59.00
60. 00 06000 LABORATORY	0	0	0	863, 026	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0	0	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	311, 578	0	0	116, 269	0	65.00
66. 00 06600 PHYSI CAL THERAPY	o	0	0	69, 670	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	19, 910	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	163, 603	0	0	90, 877	0	69. 00
69. 01 06901 CARDI AC REHAB	56, 011	0	0	0	0	69. 01
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	70. 00 71. 00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENT		0	0	0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0	5, 049, 251	0	0	73. 00
73. 01 07301 ULTRA SOUND		0	0,017,201	Ö	0	73. 01
74. 00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
91. 00 09100 EMERGENCY	512, 493	0	0	1, 338, 371	659, 926	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 347, 964	3, 120, 263	5, 049, 251	3, 474, 751	3, 108, 598	110 00
NONREI MBURSABLE COST CENTERS	4, 347, 704	3, 120, 203	5, 047, 251	3, 474, 731	3, 100, 370	1110.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	O	0	0	0	0	192. 00
192. 01 19201 HEALTH TRACKS	o	0	0	0		192. 01
194.00 07950 PRIMARY CARE CLINIC	0	0	0	0		194. 00
194.01 07951 PARTNERS IN CARE	o	0	0	0	0	194. 01
194. 02 07952 OCCUPATI ONAL MEDICINE	0	O	0	o		194. 02
194. 03 07953 FOUNDATI ON	0	0	0	0		194. 03
194. 04 07954 SCHOOL & TOWN CLINICS	0	0	0	0		194. 04
194. 05 07955 MANAGED FACILITY	0	0	0	0		194. 05
194. 06 07956 RENTAL PROPERTIES	0	0	0	0		194. 06
194.07 07957 SNF NON CERTIFIED	124, 911	O	0	O	0	194. 07
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers			0	0	0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	4, 472, 875	3, 120, 263	5, 049, 251	3, 474, 751		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	., ., 2, 3, 5	2, 120, 200	2, 31.7, 201	=,, .0.1	2, .55, 576	,

HENDRICKS REGIONAL HEALTH

| Period: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0005

						To 12/31/2017 Date/Time F	
		Cost Center Description	Subtotal	Intern &	Total	5/30/2018	4: 38 piii
		·		Residents Cost			
				& Post Stepdown			
				Adjustments			
	GENED	AL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1.00		NEW CAP REL COSTS-BLDG & FIXT					1. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT					5. 00 7. 00
8.00	00800	LAUNDRY & LINEN SERVICE					8. 00
9.00		HOUSEKEEPI NG					9. 00
10. 00 11. 00		DI ETARY CAFETERI A		•			10. 00 11. 00
13.00	01300	NURSING ADMINISTRATION					13. 00
14.00		CENTRAL SERVICES & SUPPLY					14.00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY		•			15. 00 16. 00
17. 00	01700	SOCIAL SERVICE					17. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	22 140 (22	ما	22 140 7	2.2	20.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	32, 149, 633 4, 584, 732	0	32, 149, 63 4, 584, 73		30. 00 31. 00
43. 00	04300	NURSERY	1, 117, 916	0	1, 117, 9	16	43. 00
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0	0		0	44. 00
50. 00		OPERATING ROOM	16, 133, 778	0	16, 133, 7	78	50.00
50. 01		ENDOSCOPY	2, 543, 897	0	2, 543, 89		50. 01
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	4, 809, 969 1, 867, 364	0	4, 809, 90 1, 867, 30		51. 00 52. 00
53. 00		ANESTHESI OLOGY	2, 029, 934	Ö	2, 029, 93		53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	11, 365, 332	0	11, 365, 33		54. 00
54. 01 56. 00	1	RADIATION-ONCOLOGY NUCLEAR MEDICINE - DIAGNOSTIC	24, 020, 138 544, 219	0	24, 020, 13 544, 2		54. 01 56. 00
59. 00	1	CARDI AC CATHETERI ZATI ON	1, 884, 594	Ö	1, 884, 59		59. 00
60.00	1	LABORATORY	11, 289, 289	0	11, 289, 28		60.00
64. 00 65. 00	1	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	1, 845, 143 4, 938, 610	0	1, 845, 14 4, 938, 6		64. 00 65. 00
66. 00	06600	PHYSI CAL THERAPY	10, 078, 526	O	10, 078, 52		66. 00
67. 00		OCCUPATIONAL THERAPY	740, 668	0	740, 66		67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	662, 238 1, 739, 126	0	662, 23 1, 739, 12		68. 00 69. 00
69. 01	06901	CARDI AC REHAB	1, 147, 117	0	1, 147, 1	17	69. 01
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	429, 825 0	0	429, 82	25 0	70. 00 71. 00
71.00		IMPL. DEV. CHARGED TO PATIENT	7, 024, 537	0	7, 024, 53		72.00
73. 00		DRUGS CHARGED TO PATIENTS	17, 851, 535	0	17, 851, 53		73. 00
73. 01 74. 00		ULTRA SOUND RENAL DIALYSIS	779, 265 234, 066	0	779, 20 234, 00		73. 01 74. 00
74.00		TIENT SERVICE COST CENTERS	234, 000	<u> </u>	254, 00		74.00
	1	CLINIC	8, 012, 524	0	8, 012, 52		90.00
	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	12, 537, 458	0	12, 537, 4	58	91. 00 92. 00
	SPECIA	AL PURPOSE COST CENTERS		- 1			
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	182, 361, 433	0	182, 361, 43	33	118. 00
192.00		PHYSICIANS' PRIVATE OFFICES	66, 891, 968	0	66, 891, 90	68	192. 00
		HEALTH TRACKS	5, 425, 156	O	5, 425, 1		192. 01
		PRIMARY CARE CLINIC PARTNERS IN CARE	4, 308, 957 1, 442, 214	0	4, 308, 99 1, 442, 2		194. 00 194. 01
		OCCUPATIONAL MEDICINE	1, 293, 486	Ö	1, 293, 48		194. 02
		FOUNDATION	292, 761	0	292, 70		194. 03
		SCHOOL & TOWN CLINICS MANAGED FACILITY	2, 209, 154 509, 124	0	2, 209, 15 509, 12		194. 04 194. 05
194.06	07956	RENTAL PROPERTIES	-14, 994	Ö	-14, 99	94	194. 06
		SNF NON CERTIFIED	2, 802, 709	0	2, 802, 70	09	194. 07
200.00 201.00		Cross Foot Adjustments Negative Cost Centers	0	0		0	200. 00 201. 00
202.00		TOTAL (sum lines 118 through 201)	267, 521, 968	0	267, 521, 96	68	202. 00

| Period: | Worksheet B | From 01/01/2017 | Part II | To | 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0005

					j i	o 12/31/2017	Date/Time Pre	
				CAPITAL			5/30/2018 4: 3	8 pm
				RELATED COSTS				
		Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
			Assigned New	FLXT		BENEFITS	& GENERAL	
			Capi tal			DEPARTMENT		
			Related Costs 0	1.00	2A	4. 00	5. 00	
	GENER	AL SERVICE COST CENTERS	0	1.00	2/1	4.00	3.00	
1.00		NEW CAP REL COSTS-BLDG & FIXT						1. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	0	194, 621	194, 621	194, 621		4. 00
5.00		ADMINISTRATIVE & GENERAL	0	1, 471, 518				5. 00
7.00		OPERATION OF PLANT	0	2, 246, 975			l	7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	276, 841 124, 276	1	555 3, 424	l	8. 00 9. 00
10. 00		DI ETARY	0	487, 557			l	10.00
11. 00	1	CAFETERI A	0	86, 586	1			
13.00	01300	NURSING ADMINISTRATION	0	252, 015			22, 001	13. 00
14. 00		CENTRAL SERVICES & SUPPLY	0	450, 914			1	
15. 00	1	PHARMACY	0	198, 987			1	15. 00
16.00		MEDICAL RECORDS & LIBRARY	0	209, 493				
17. 00		SOCIAL SERVICE ENT ROUTINE SERVICE COST CENTERS		91, 679	91, 679	2, 895	16, 920	17. 00
30. 00		ADULTS & PEDIATRICS	0	2, 048, 163	2, 048, 163	20, 695	113, 496	30. 00
31. 00		INTENSIVE CARE UNIT	0	,	1		17, 315	
43.00		NURSERY	0	48, 546	48, 546	617	3, 527	43. 00
44.00		SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
		LARY SERVICE COST CENTERS	1	101.110	1 404 440			
50. 00 50. 01		OPERATING ROOM ENDOSCOPY	0	484, 413 156, 698				50.00
50.01		RECOVERY ROOM	0	797, 780	1			50. 01 51. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	0	164, 643			7, 761	52.00
53. 00		ANESTHESI OLOGY	0	0	1		10, 089	
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	886, 112	886, 112	6, 756	50, 644	54.00
54. 01	1	RADI ATI ON-ONCOLOGY	0	573, 036			1	
56. 00		NUCLEAR MEDICINE - DIAGNOSTIC	0	15, 338				
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	0	277, 452 303, 908			7, 101 54, 308	59. 00 60. 00
64. 00		INTRAVENOUS THERAPY	0	39, 436			l	64. 00
65. 00		RESPI RATORY THERAPY	0	334, 817			l	65. 00
66.00	06600	PHYSI CAL THERAPY	0	523, 704			51, 609	66. 00
67. 00		OCCUPATIONAL THERAPY	0	53, 552	53, 552	618	3, 720	67. 00
68. 00		SPEECH PATHOLOGY	0	69, 123			2, 966	
69.00		ELECTROCARDI OLOGY	0	121, 831	1			
69. 01 70. 00		CARDI AC REHAB ELECTROENCEPHALOGRAPHY	0	142, 611 78, 058		721 154	5, 080 1, 376	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	78,030	1		1, 370	71.00
72. 00	1	IMPL. DEV. CHARGED TO PATIENT	0	0		0	39, 292	72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	71, 609	73. 00
73. 01		ULTRA SOUND	0	19, 849	1		4, 019	
74. 00		RENAL DIALYSIS	0	0	0	0	1, 239	74. 00
90. 00		TIENT SERVICE COST CENTERS CLINIC	0	586, 861	586, 861	2, 701	43, 302	90. 00
91. 00		EMERGENCY			1		l	
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART)		000, 100	000, 100		10, 170	92. 00
		AL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	14, 731, 998	14, 731, 998	129, 242	1, 029, 306	118. 00
400.00		I MBURSABLE COST CENTERS	1				074 705	
		PHYSICIANS' PRIVATE OFFICES	0	-, ,				
		HEALTH TRACKS PRIMARY CARE CLINIC	0	361, 622 323, 699			1	
		PARTNERS IN CARE	0	138, 129				194. 00
		OCCUPATIONAL MEDICINE	0	137, 751	1	409	l	194. 02
194. 03	07953	FOUNDATI ON	0	14, 057	14, 057	238		194. 03
	1	SCHOOL & TOWN CLINICS	0	33, 412		2, 183		
		MANAGED FACILITY	0	0	0	0	l	194. 05
	1	RENTAL PROPERTIES	0	0	0	0	l	194. 06
200.00		SNF NON CERTIFIED Cross Foot Adjustments		384, 760	384, 760	1, 614	11, 103	200. 00
200.00	1	Negative Cost Centers		0	١	n	n	200.00
202.00	1	TOTAL (sum lines 118 through 201)	0	1		194, 621	l e	
		.						

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2017 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0005

				To	12/31/2017		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/30/2018 4: 3 CAFETERI A	8 pm
		PLANT	LINEN SERVICE				
	CNEDAL CEDVICE COCT CENTEDS	7.00	8. 00	9. 00	10. 00	11. 00	
	SENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT			•			4. 00
1	00500 ADMINISTRATIVE & GENERAL			•			5. 00
	00700 OPERATION OF PLANT	2, 334, 008					7. 00
	00800 LAUNDRY & LINEN SERVICE	0	285, 041				8. 00
	00900 HOUSEKEEPI NG	32, 596	0	1			9. 00
10.00 0	1000 DI ETARY	127, 881	0	6, 237	629, 651		10. 00
11. 00 0	01100 CAFETERI A	22, 710	0	0	0	123, 622	11. 00
13. 00 0	01300 NURSING ADMINISTRATION	66, 101	0	1, 448	0	4, 431	13. 00
14.00 0	01400 CENTRAL SERVICES & SUPPLY	118, 270	88	3, 541	0	2, 941	14. 00
	1500 PHARMACY	52, 192	371	825	0	4, 050	1
1	11600 MEDICAL RECORDS & LIBRARY	41, 436	l e	,	0	3, 915	
	1700 SOCI AL SERVI CE	0	0	137	0	4, 239	17. 00
	NPATIENT ROUTINE SERVICE COST CENTERS	F27 242	7/ 500	72 (70	470 101	24 022	20.00
	03000 ADULTS & PEDIATRICS	537, 212	1		479, 191	24, 823	30.00
	03100 INTENSIVE CARE UNIT 04300 NURSERY	67, 261 12, 733	10, 695 4, 059	1	60, 694 89, 766	3, 930	1
	04400 SKILLED NURSING FACILITY	12, 733	4,039	1	09, 700	672 0	1
	NCI LLARY SERVI CE COST CENTERS	0		<u> </u>	·		44.00
	05000 OPERATI NG ROOM	127, 056	19, 062	12, 929	0	5, 143	50. 00
	05001 ENDOSCOPY	41, 100	l		0	2, 526	1
51.00 0	05100 RECOVERY ROOM	209, 249	l	1	0	3, 291	51.00
52. 00 0	05200 DELIVERY ROOM & LABOR ROOM	43, 184	14, 971	275	0	1, 636	52. 00
53. 00 0	05300 ANESTHESI OLOGY	0	0		0	2, 820	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	132, 835	l	1	0	10, 275	1
	05401 RADI ATI ON-ONCOLOGY	0	1, 966		0	3, 249	1
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	4, 023	0	328	0	306	1
1	05900 CARDI AC CATHETERI ZATI ON	72, 773	0	_, -,	0	1, 159	59.00
	06000 LABORATORY	68, 872	34		0	8, 111	1
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	10, 344 78, 307	1, 153	1	0	1, 684 5, 307	64. 00 65. 00
	06600 PHYSI CAL THERAPY	53, 658	1		0	11, 816	1
	06700 OCCUPATI ONAL THERAPY	3, 305	17, 374	803	0	777	67. 00
	06800 SPEECH PATHOLOGY	18, 130	1		0	474	68. 00
1	06900 ELECTROCARDI OLOGY	31, 955	l .		o	2, 786	69. 00
69. 01 0	06901 CARDI AC REHAB	22, 565	99	846	0	954	69. 01
70. 00 0	77000 ELECTROENCEPHALOGRAPHY	20, 474	240	1, 765	0	458	70. 00
71. 00 0	77100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	07301 ULTRA SOUND	5, 206			0	994	
	07400 RENAL DIALYSIS	0	35	497	0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS	0	18, 437	7, 326	ol	0	90.00
	19000 CETNIC 19100 EMERGENCY	172, 630	· ·		ol Ol	8, 728	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	172,030	37,017	13, 330	o _l	0, 720	92.00
	PECIAL PURPOSE COST CENTERS						72.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2, 194, 058	272, 002	163, 228	629, 651	121, 495	118. 00
N	ONREI MBURSABLE COST CENTERS				•		
	9200 PHYSI CLANS' PRI VATE OFFI CES	8, 718			0		192. 00
	9201 HEALTH TRACKS	0	1, 685		0		192. 01
	07950 PRIMARY CARE CLINIC	0	143	1	0		194. 00
	77951 PARTNERS IN CARE	30, 314	186		0		194. 01
	07952 OCCUPATIONAL MEDICINE	0	502		0		194. 02
	07953 FOUNDATION 07954 SCHOOL & TOWN CLINICS	0	0 105		0		194. 03 194. 04
	07954 SCHOOL & TOWN CLINICS 07955 MANAGED FACILITY	0	105	1	o A		194. 04
	17956 RENTAL PROPERTIES			0	0		194. 05
	77957 SNF NON CERTIFIED	100, 918	2, 436	_	0		194. 07
200.00	Cross Foot Adjustments	.55, 716	2, 130		٩	2, 127	200. 00
201. 00	Negative Cost Centers	0	О	o	o	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	2, 334, 008	285, 041	184, 921	629, 651	123, 622	

Provider CCN: 15-0005

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Part II | Par

			To	12/31/2017	Date/Time Pre 5/30/2018 4:3	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	O PIII
·	ADMI NI STRATI ON	SERVICES &		RECORDS &		
	10.00	SUPPLY	45.00	LI BRARY	17.00	
GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
13.00 O1300 NURSING ADMINISTRATION	349, 407					13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	589, 455				14. 00
15. 00 01500 PHARMACY	0	0	285, 607	075 544		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	275, 511	115 070	16.00
17. 00 O1700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	U	0	0	115, 870	17. 00
30. 00 03000 ADULTS & PEDIATRICS	113, 864	0	0	31, 445	82, 361	30.00
31. 00 03100 NTENSI VE CARE UNI T	18, 027	0	0	7, 116	8, 911	31.00
43. 00 04300 NURSERY	3, 084	0	0	0	0,711	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	23, 589	589, 455	0	0	0	50. 00
50. 01 05001 ENDOSCOPY	11, 586	0	0	0	0	50. 01
51. 00 05100 RECOVERY ROOM	15, 093	0	0	12, 159	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	7, 502	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	12, 935	0	0	24 404	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 RADI ATI ON-ONCOLOGY	47, 126 0	0	0	26, 696	0	54. 00 54. 01
56. OO 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 314	0	0	0	0	59.00
60. 00 06000 LABORATORY	0	0	0	68, 411	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	O	0	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	24, 340	0	0	9, 216	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	5, 523	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	1, 578	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	12, 780	0	0	7, 204	0	69.00
69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 375 0	0	0	0	0	69. 01 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	o o	0	0	Ö	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	0	285, 607	0	0	73. 00
73.01 07301 ULTRA SOUND	0	0	0	0	0	73. 01
74. 00 07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
OUTPATIENT SERVICE COST CENTERS				_1		
90. 00 09000 CLI NI C	0	0	0	10/ 1/3	0	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	40, 034	0	0	106, 163	24, 598	91. 00 92. 00
SPECIAL PURPOSE COST CENTERS						92.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	339, 649	589, 455	285, 607	275, 511	115, 870	118. 00
NONREI MBURSABLE COST CENTERS	3377317	0077 100	200,007	2707011	110,070	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00
192. 01 19201 HEALTH TRACKS	0	0	0	0		192. 01
194.00 07950 PRIMARY CARE CLINIC	0	0	0	0		194. 00
194. 01 07951 PARTNERS IN CARE	0	0	0	0		194. 01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	0	0	0	0		194. 02
194. 03 07953 FOUNDATION	0	0	0	0		194. 03
194.04 07954 SCHOOL & TOWN CLINICS 194.05 07955 MANAGED FACILITY	0	0	0	0		194. 04 194. 05
194.06 07956 MANAGED FACILITY 194.06 07956 RENTAL PROPERTIES		0	0	O O		194. 05
194. 07 07957 SNF NON CERTIFIED	9, 758	0	0	0		194. 00
200.00 Cross Foot Adjustments	,,,,,,,	Ĭ	٦	Ĭ		200. 00
201.00 Negative Cost Centers	0	0	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	349, 407	589, 455	285, 607	275, 511	115, 870	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS In Lieu of Form CMS-2552-10 HENDRICKS REGIONAL HEALTH Worksheet B
Part II
Date/Time Prepared:
5/30/2018 4:38 pm Provider CCN: 15-0005 Peri od: From 01/01/2017 To 12/31/2017 Cost Center Description Subtotal Intern & Total

	Cost Center Description	Subtotai	Residents Cost	тотаг	
			& Post		
			Stepdown		
			Adjustments		
		24. 00	25. 00	26. 00	
	RAL SERVICE COST CENTERS		<u> </u>		4 00
	NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT				1. 00 4. 00
	ADMINISTRATIVE & GENERAL				5. 00
	OPERATION OF PLANT				7. 00
	LAUNDRY & LINEN SERVICE				8. 00
	HOUSEKEEPI NG				9. 00
10.00 01000	D DI ETARY				10. 00
	CAFETERI A				11. 00
	NURSING ADMINISTRATION				13. 00
	CENTRAL SERVICES & SUPPLY				14. 00
	PHARMACY				15. 00
	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE				16. 00 17. 00
	TIENT ROUTINE SERVICE COST CENTERS				17.00
	ADULTS & PEDIATRICS	3, 601, 508	0	3, 601, 508	30.00
	INTENSIVE CARE UNIT	459, 511	ő	459, 511	31. 00
	NURSERY	163, 585		163, 585	43. 00
	SKILLED NURSING FACILITY	0	1	. 0	44. 00
ANCI L	LARY SERVICE COST CENTERS				
	OPERATING ROOM	1, 329, 201	0	1, 329, 201	50. 00
	ENDOSCOPY	235, 754		235, 754	50. 01
	RECOVERY ROOM	1, 079, 524	1	1, 079, 524	51.00
	DELIVERY ROOM & LABOR ROOM	241, 340	1	241, 340	52.00
	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	34, 611 1, 199, 236	0	34, 611 1, 199, 236	53. 00 54. 00
	RADI ATI ON-ONCOLOGY	717, 773		717, 773	54. 00
	NUCLEAR MEDICINE - DIAGNOSTIC	23, 078		23, 078	56.00
	CARDI AC CATHETERI ZATI ON	367, 272	1	367, 272	59. 00
	LABORATORY	513, 002	1	513, 002	60.00
64. 00 06400	INTRAVENOUS THERAPY	64, 183	0	64, 183	64. 00
	RESPI RATORY THERAPY	477, 633	0	477, 633	65. 00
	PHYSI CAL THERAPY	678, 759	1	678, 759	66. 00
	OCCUPATIONAL THERAPY	64, 353	0	64, 353	67. 00
	SPEECH PATHOLOGY	91, 441	0	91, 441	68. 00
	ELECTROCARDI OLOGY I CARDI AC REHAB	190, 423 177, 251	0	190, 423 177, 251	69. 00 69. 01
	ELECTROENCEPHALOGRAPHY	102, 525	1	102, 525	70.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	102, 323	0	102, 323	71.00
	IMPL. DEV. CHARGED TO PATIENT	39, 292	o	39, 292	72. 00
	DRUGS CHARGED TO PATIENTS	357, 216	О	357, 216	73. 00
73. 01 07301	ULTRA SOUND	31, 169	0	31, 169	73. 01
	RENAL DIALYSIS	1, 771	0	1, 771	74. 00
	ATIENT SERVICE COST CENTERS				4
90. 00 09000	•	658, 627	1	658, 627	90.00
91.00 09100	OBSERVATION BEDS (NON-DISTINCT PART)	1, 112, 953	1	1, 112, 953	91. 00 92. 00
	AL PURPOSE COST CENTERS		0		72.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	14, 012, 991	0	14, 012, 991	118. 00
	EI MBURSABLE COST CENTERS	11/012/771	<u> </u>	11/012/771	1.10.00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	6, 644, 757	0	6, 644, 757	192. 00
	HEALTH TRACKS	402, 221	0	402, 221	192. 01
	PRIMARY CARE CLINIC	349, 913		349, 913	194. 00
	PARTNERS IN CARE	177, 675		177, 675	194. 01
	OCCUPATIONAL MEDICINE	148, 212		148, 212	194. 02
194. 03 07953		15, 996	1	15, 996	194. 03
	SCHOOL & TOWN CLINICS MANAGED FACILITY	48, 136 2, 848	1	48, 136 2, 848	194. 04 194. 05
	RENTAL PROPERTIES	∠, 048 ∩		2, 848 0	194. 05
	SNF NON CERTIFIED	512, 716		512, 716	194. 07
200. 00	Cross Foot Adjustments	0.2,7.10	l ől	012,710	200. 00
201. 00	Negative Cost Centers	0	ol	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	22, 315, 465	o	22, 315, 465	202. 00

				Τ̈́	o 12/31/2017	Date/Time Pre 5/30/2018 4:3	
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)		O pili
		1.00	SALARI ES) 4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS			J 071	0.00	7.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	766, 739					1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 687	121, 691, 815	1			4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	50, 560	15, 540, 117				5. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	77, 204 9, 512	2, 584, 991 346, 844	1	, ,	305, 748 0	8.00
9. 00	00900 HOUSEKEEPING	4, 270	2, 141, 645	1			9. 00
10.00	01000 DI ETARY	16, 752	509, 404	1			
11.00	01100 CAFETERI A	2, 975	1, 283, 712	1		2, 975	1
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	8, 659 15, 493	2, 133, 391 785, 696	i			1
15. 00	01500 PHARMACY	6, 837	2, 092, 668	1			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	7, 198	1, 119, 116	0	2, 678, 855	5, 428	16. 00
17. 00	01700 SOCI AL SERVI CE	3, 150	1, 810, 200	0	2, 614, 784	0	17. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	70, 373	12, 942, 483	0	17, 539, 218	70, 373	30.00
31. 00	03100 INTENSIVE CARE UNIT	8, 811	1, 685, 911	1		'	31.00
43. 00	04300 NURSERY	1, 668	385, 680	1			1
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	1/ /44	2 200 707		0.040.704	1/ /44	
50. 00 50. 01	05000 OPERATI NG ROOM 05001 ENDOSCOPY	16, 644 5, 384	2, 390, 707 1, 063, 015				50. 00 50. 01
51. 00	05100 RECOVERY ROOM	27, 411	1, 281, 311	1			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 657	855, 696	О			52. 00
53. 00	05300 ANESTHESI OLOGY	0	5, 297, 545	1			53. 00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI ATI ON-ONCOLOGY	30, 446 19, 689	4, 225, 302	1			54. 00 54. 01
56. 00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	527	1, 214, 474 162, 850				56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	9, 533	591, 669	1			
60.00	06000 LABORATORY	10, 442	2, 685, 575	0	8, 392, 515	9, 022	60.00
64. 00	06400 I NTRAVENOUS THERAPY	1, 355	934, 304	1			
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	11, 504 17, 994	1, 991, 723 5, 037, 181	1	-,,	10, 258 7, 029	
67. 00	06700 OCCUPATI ONAL THERAPY	1, 840	386, 672	1			
68. 00	06800 SPEECH PATHOLOGY	2, 375	269, 582	1			
69. 00	06900 ELECTROCARDI OLOGY	4, 186	557, 812	1			
69. 01	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	4, 900	450, 606	1			
70. 00 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 682	96, 499 0	i		2, 682 0	70. 00 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	l o	0	Ö		Ö	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		0	73. 00
73. 01	07301 ULTRA SOUND	682	464, 092	i			1
74.00	07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0	0	0	191, 475	0	74.00
90.00	09000 CLINI C	20, 164	1, 689, 250	0	6, 691, 722	0	90.00
91.00	09100 EMERGENCY	22, 614	3, 819, 120	0	7, 136, 095	22, 614	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	506, 178	80, 826, 843	-36, 279, 685	159, 064, 437	287, 415	118. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	212, 684	33, 346, 454	0	57, 461, 481	1, 142	192. 00
192. 01	19201 HEALTH TRACKS	12, 425	2, 979, 753	0	4, 586, 144	0	192. 01
	07950 PRIMARY CARE CLINIC	11, 122	1, 114, 184	1			194. 00
	07951 PARTNERS IN CARE 07952 OCCUPATIONAL MEDICINE	4, 746 4, 733	645, 413 255, 634	1			194. 01 194. 02
	07953 FOUNDATION	483	148, 828	1	.,,		194. 02
	07954 SCHOOL & TOWN CLINICS	1, 148	1, 365, 023	1			194. 04
	07955 MANAGED FACILITY	0	0	1			194. 05
	07956 RENTAL PROPERTIES	12 220	1 000 403	14, 994			194. 06
200.00	O7957 SNF NON CERTIFIED Cross Foot Adjustments	13, 220	1, 009, 683	0	1, 715, 867	13, 220	200. 00
201.00							201. 00
202.00	Cost to be allocated (per Wkst. B,	22, 315, 465	5, 289, 445		36, 279, 685	14, 820, 771	1
202.00	Part I)	20 104202	0.042444		0 154000	40 472012	202 00
203. 00 204. 00		29. 104382	0. 043466 194, 621	1	0. 156880 1, 496, 367		1
204. UU	Part II)		194, 021		1, 490, 307	2, 334, 008	204.00
205.00	Unit cost multiplier (Wkst. B, Part		0. 001599		0. 006471	7. 633764	205. 00
)	1					<u> </u>

Heal th Fina	ncial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 4:3	
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliatio	n ADMI NI STRATI VE	OPERATION OF	
		FLXT	BENEFITS		& GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM. COST)	(SQUARE	
		FEET)	(GROSS			FEET)	
		ŕ	SALARI ES)			,	
		1. 00	4. 00	5A	5. 00	7. 00	
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 Provider CCN: 15-0005

13.00 0.300 NIRST NO ADMINISTRATION 0 1.37 0 60.908 1.047,252 0.1500 0.1500 PIARDARY 1.509 76 0 55.677 0 0.1500 PIARDARY 1.509 76 0 55.677 0 0.1600 0.1600 PIARDARY 1.509 76 0 55.677 0 0.1600 0.1600 PIARDARY 1.509 0.1600 0.1600 PIARDARY 1.509 0.1600 0.160						12/31/2017	5/30/2018 4: 3	
COUNTING OF CAPACITY COUNTING OF CAPACITY COUNTING OF CAPACITY COUNT	Cost Cen	ter Description						
DEMERAL SERVICE COST CENTERS 8 00 9 00 10 00 11 00 13 00						(MANHOURS)	ADMI NI STRATI ON	
CONTRIBUTION SERVICE COST CRIVETES				SERVICE)	DAYS)		(DI DECT	
DEBERAL SERVICE COST CENTERS 8.00 9.09 10.00 11.00 13.00			LAUNDKI)					
CEMBERAL SERVICE COST CENTERS			8.00	9. 00	10.00	11. 00		
0.000 DIMINISTRATIVE & GÉMERAL	GENERAL SERVIC	CE COST CENTERS	,			'		
0.0000 0.00000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000	1.00 00100 NEW CAP	REL COSTS-BLDG & FLXT						1.00
0.07000 DOTROID OF PEATER								4.00
8.00 0.0000 LAURDRY & LINEN SERVICE 1,227,477 0 70,00 21,485 1,000,467 1,000 1,000 1,000 1,000,467 1,000 1,000 1,000,467								5. 00
9.00 0.0900 BUSEREP INC 0 17, 493 11.00 10.00 10.00 10.00 11.00 17.			4 007 407					7. 00
10.00 01000 DETARY 0 500 21,485 1,000 131 10.00 10100 0.00 1,409,467 1,000 131 10.00 10100 0.00 1,409,467 1,000 131 10.00 10100 131 10.00 10.00 131 131			1, 227, 497	17 400				8.00
11.00 01100 CAFETERIA 0 0 1.609, 467 14.00 01400 CENTRAL STRAYLORS & SURPLY 3379 335 0 40, 428 15.00 01500 MEDICAL ECORDS & LIBRARY 0 1.69 78 0 55, 677 0 16.00 01500 MEDICAL ECORDS & LIBRARY 0 1.69 78 0 55, 677 0 16.00 01500 MEDICAL ECORDS & LIBRARY 0 1.69 78 0 53, 817 0 16.00 01500 MEDICAL ECORDS & LIBRARY 0 1.69 78 0 53, 817 0 17.00 01500 MEDICAL ECORDS & LIBRARY 0 1.69 30, 81 270 18.00 03000 ADULT & SPEVICE COST CENTERS	l l	PING	0		1			9.00
13.00 01300 MURSI NO. ADMINISTRATION 0 137 0 0,000 8 1,047,252		۸			1	1 600 467		11.00
14.00 01400 PARMACY 0 14.0 40.0 53,117 0 16.00 01500 PARMACY 0 14.0 0 53,117 0 0 17.0 01700 01			1	-	_		1 047 252	
15.00 01500 PHARMACY 1.599 78			1					
17.00			1					
INPATT ENT ROUTH IN SERVICE COST CENTERS 329,825 6,996 16,351 341,277 341,277 310,00 30100 INTENSIVE CARE UNIT 46,056 608 2,071 54,030 54,030 54,030 34			1		1		0	
30.00			0	13	0	58, 274	0	17. 00
31.00 03100 INTENSIVE CARE UNIT								
43.00 04300 NURSERY 17.479 55 3.063 9.243 9.243								1
0 0400 SKILLER NURSING FACILITY 0 0 0 0 0 0 0 0 0		E CARE UNIT	1					1
AMOLILLARY SERVICE COST CENTERS	1 1	NUDCING FACILITY	1			9, 243		1
50.00			U U	0	0	U	0	44. 00
10 10 10 10 10 10 10 10			92 000	1 222		70. 702	70. 702	50.00
51 00 05100 RECOVERY ROOM 51,587 222 0 45,237 45,237 45,237 45,237 45,237 45,237 45,237 45,237 30 05300 NEISTHESI OLOGY 0 28 0 38,768 38,76					1			1
52 00 05200 DELLETRO ROM & LABOR ROOM 64,470 26 0 22,484 22,484 54,00 05400 ARSTHESI DLOGY 0 0 28 0 38,768 38,768 38,768 34,768								1
53.00 05300 ANESTHESI OLOGY 0 28 0 38, 768 38, 768 54.00 05400 RADIOLOGY 01 AGNOSTIC 135, 552 692 0 141, 248 141, 248 54.01 05401 RADIATION-ONCOLOGY 8, 466 398 0 44, 660 036 0.00 05900 OLEGAR MEDICINE - DIAGNOSTIC 0 0 31 0 0, 4, 211 0 0 0.00 0								
54 0 0540 RADIATION-ONCOLOGY 8, 466 598 0 44, 660 0 0 0 0 0 0 0 0 0			1		1		38, 768	53.00
56 00 03450 NUCLEAR MEDICINE - DI AGNOSTIC 0 31 0 4,211 0 0 0 0 0 0 0 0 0	54. 00 05400 RADI OLOG	Y-DI AGNOSTI C	135, 552	692	0	141, 248	141, 248	54.00
59,00 OSPOOL CARDIAC CATHETERIZATION 0 239 0 15,928 15,928 15,928 16,000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000	54. 01 05401 RADI ATI 0	N-ONCOLOGY	8, 466	398	0	44, 660	0	54. 01
60.00 0.0000 LABORATORY 147 479 0 111, 500 0 0.40 0.0000 INTERVENUES THERAPY 0 63 0 72, 951 72			0	31	0		0	56. 00
64.00			1		1			1
65. 00 06500 RESPIRATORY THERAPY 0 6.3 0 72, 951 72, 951 72, 951 72, 951 72, 951 72, 951 72, 951 72, 951 72, 951 72, 951 72, 951 73, 951 74,			1					
66.00 06600 PHYSI CAL THERAPY 83, 431 475 0 162, 437 0 67.00 67.00 06700 0CUPATIONAL THERAPY 0 76 0 10, 683 0 0 0 0 0 0 0 0 0			4, 965		1			
67:00 06700 0CCUPATIONAL THERAPY 0 76 0 10,883 0 06.80 06800 SPECH PATHOLOGY 0 30 0 0 6,511 0 0900 06900 ELECTROCARDIOLOGY 19,747 180 0 38,305 38,305 38,305 09.01 06901 06801			02 421		1			1
68.00 06800 SPECH PATHOLOGY 0 30 0 6, 511 0 69.00 06900 LECTROCARDIOLOGY 19,747 180 0 38, 305 38, 305 69.01 06901 CARDI AC REHAB 428 80 0 13, 114 13, 114 70.00 07000 LECTROCARDIOLOGY 19,747 180 0 6, 302 0 71.00 07000 LECTROCARDIOLOGAPHY 1,034 167 0 6, 302 0 71.00 07000 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 73.01 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.01 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 74.00 7400 ADMINISTRA SOUND 0 34 0 13,659 0 74.00 7400 ADMINISTRA SOUND 0 34 0 13,659 0 74.00 7400 ADMINISTRA SOUND 0 0 0 0 75.01 07301 ULTRA SOUND 0 34 0 13,659 0 76.00 O9000 CLINIC 0 79,396 693 0 0 0 0 77.00 09100 EMERGENCY 159,420 1,261 0 119,992 119,992 77.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 78.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) 78.00 O9200 DESERVATION BEDS (NON-DISTINCT PART) 79.01 O9200 PHYSI CI ANS' PRIVATE OFFICES 34,373 1,223 0 0 0 79.01 O9200 PHYSI CI ANS' PRIVATE OFFICES 34,373 1,223 0 0 0 79.01 O9200 PHYSI CI ANS' PRIVATE OFFICES 34,373 1,223 0 0 0 0 79.01 O9200 PHYSI CI ANS' PRIVATE OFFICES 34,373 1,223 0 0 0 0 79.01 O9200 PHYSI CI ANS' PRIVATE OFFICES 34,373 1,223 0 0 0 0 79.01 O9200 PHYSI CI ANS' PRIVATE OFFICES 34,373 1,223 0 0 0 0 79.01 O9200 PHYSI CI ANS' PRIVATE OFFICES 34,373 1,223 0 0 0 0 79.01 O9200 PHYSI CI ANS' PRIVATE OFFICES 34,373 1,223 0 0 0 0 79.01 O9200 PHYSI CI ANS' PRIVATE OFFICES 34,373 1,223 0 0 0 0 79.01 O9200 PHYSI CI ANS' PRIVATE OFFICES 34,373 1,223 0 0 0 0 79.01 O9200 PHYSI CI ANS' PRIVATE OFFICES 34,373 1,223 0 0 0 0 79.01 O9200 PHYSI CI ANS' P			1		1			
69.00 06900 CADOLAC REHAB 428 80			1					
69.01			1		1			
170.00					1			1
771.00					1			1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 1 0 0 0 173.01 ULTRA SOUND 0 34 0 13.659 0 0 74.00 07400 [RNAL DIALYSIS 151 47 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		1	0	0	71.00
73.01 07301 ULTRA SOUND 0 34 0 13,659 0 0 0 0 0 0 0 0 0	72.00 07200 I MPL. DE	V. CHARGED TO PATIENT	0	0	0	0	0	72.00
74. 00 07400 RENAL DIALYSIS 151 47 0 0 0 0 0 0 0 0 0	73.00 07300 DRUGS CH	ARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0	1 1		1		0	13, 659		
90. 0			151	47	0	0	0	74.00
91.00 09100 EMERGENCY 159, 420 1, 261 0 119, 992 119		RVICE COST CENTERS	70.00/	(00		ام		
92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 18.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,171,352 15,441 21,485 1,670,221 1,018,006 1 10,000	1 1	V			1			
SPECIAL PURPOSE COST CENTERS 1, 670, 221 1, 018, 006 1 1 1 1 1 1 1 1 1			159, 420	1, 261	١	119, 992	119, 992	91.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,171,352 15,441 21,485 1,670,221 1,018,006 NONREI MBURSABLE COST CENTERS 34,373 1,223 0 0 0 0 1 1 1 1 1 1								92.00
NONREI MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 34, 373 1, 223 0 0 0 0 1 192.0			1, 171 352	15 441	21 485	1, 670, 221	1, 018, 006	118 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES 34, 373 1, 223 0 0 0 19201 HEALTH TRACKS 7, 255 423 0 0 0 0 194. 00 194. 00 197950 PRI MARY CARE CLINIC 614 21 0 0 0 0 194. 01 07951 PARTNERS IN CARE 799 113 0 0 0 0 194. 02 07952 0CCUPATIONAL MEDICINE 2, 161 256 0 0 0 0 0 194. 03 07953 FOUNDATION 0 7 0 0 0 0 194. 03 07953 FOUNDATION 0 7 0 0 0 0 194. 05 07955 MANAGED FACILITY 0 0 0 0 0 0 194. 05 07955 MANAGED FACILITY 0 0 0 0 0 0 0 194. 05 07956 RENTAL PROPERTIES 0 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 10, 491 0 0 29, 246 29, 246 194. 07 07957 SNF NON CERTIFIED 10, 491 0 29, 246 29, 246 194. 07 07957 Cost to be allocated (per Wkst. B, Part I) 1.113407 263. 499743 104. 614708 1.375951 4.271059 204. 00 Cost to be allocated (per Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 1.113407 263. 499743 104. 614708 1.375951 4.271059 205. 00 Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated 220. 00 NAHE adjustment amount to be allocated 240. 00 NAHE adjustment amount amount and the part of the part			., ., ., 1, 332	.5, 141	21, 100	., 5, 5, 221	., 5.5, 550	1
192. 01 19201 HEALTH TRACKS 194. 00 07950 PRI MARY CARE CLINIC 194. 01 07951 PARTNERS IN CARE 194. 02 07952 OCCUPATIONAL MEDICINE 194. 04 07954 SCHOOL & TOWN CLINICS 194. 05 07955 MANAGED FACILITY 194. 05 07955 MON CERTIFIED 194. 06 07950 OCCUPATIONAL MEDICINE 194. 05 07955 MON CERTIFIED 194. 06 07950 OCCUPATIONAL MEDICINE 194. 05 07955 MON CERTIFIED 194. 05 07955 OCCUPATIONAL MEDICINE 194. 05 07955 MON CERTIFIED 194. 05 07955 OCCUPATIONAL MEDICINE 194. 05 07955 MON CERTIFIED 194. 05 07956 OCCUPATIONAL MEDICINE 194. 05 07956 MONAGED FACILITY 195. 0756 MONAGED FACILITY 194. 05 07956 MONAGED FACILITY 194. 05 07956			34, 373	1, 223	0	0	0	192. 00
194. 01 07951 PARTNERS IN CARE 799 113 0 0 0 1 194. 02 07952 0CCUPATIONAL MEDICINE 2, 161 256 0 0 0 0 1 194. 03 07953 FOUNDATION 0 7 0 0 0 0 1 194. 04 07954 SCHOOL & TOWN CLINICS 452 9 0 0 0 0 1 194. 05 07955 MANAGED FACILITY 0 0 0 0 0 0 0 1 194. 06 07956 RENTAL PROPERTIES 0 0 0 0 0 0 0 1 194. 07 07957 SNF NON CERTIFIED 10, 491 0 0 29, 246 29, 246 1 200. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part II) 1.113407 263. 499743 104. 614708 1.375951 4.271059 2 204. 00 NAHE adjustment amount to be allocated 22 20. 00 NAHE adjustment amount to be allocated 22 20. 00 NAHE adjustment amount to be allocated 22 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			1			О		192. 01
194. 02 07952 OCCUPATIONAL MEDICINE 2, 161 256 0 0 0 194. 03 07953 FOUNDATION 0 7 0 0 0 194. 04 07954 SCHOOL & TOWN CLINICS 452 9 0 0 0 194. 05 07955 MANAGED FACILITY 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 0 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 10, 491 0 0 29, 246 29, 246 29, 246 200. 00 0 0 0 0 0 0 0 0						o		194. 00
194. 03 07953 FOUNDATION 0 0 0 1 194. 04 07954 SCHOOL & TOWN CLINICS 452 9 0 0 0 0 194. 05 07955 MANAGED FACILITY 0 0 0 0 0 194. 06 07956 RENTAL PROPERTIES 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 10, 491 0 0 29, 246 29, 246 29, 246 29, 246 20. 00 0 0 0 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 10, 491 0 0 0 29, 246 29, 246 29, 246 29, 246 20. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1			0		194. 01
194. 04 07954 SCHOOL & TOWN CLINICS 452 9 0 0 0 194. 05 07955 MANAGED FACILITY 0 0 0 0 0 194. 06 07956 RENTAL PROPERTIES 0 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 10, 491 0 0 29, 246 29, 2			1	256	1	0		194. 02
194. 05 07955 MANAGED FACILITY 0 0 0 0 0 0 0 194. 07956 RENTAL PROPERTIES 0 0 0 0 0 0 0 0 194. 07957 SNF NON CERTIFIED 10, 491 0 0 29, 246 29, 246 1 29, 246 1 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	7	_	0		194. 03
194.06 07956 RENTAL PROPERTIES 0 0 0 0 0 0 194.07 07957 SNF NON CERTIFIED 10, 491 0 0 29, 246 29, 246 1 29			1	9		0		194. 04
194. 07 07957 SNF NON CERTIFIED 10, 491 0 0 29, 246 29, 246 10, 491 0 0 29, 246 29, 246 29, 246 200. 00 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 1, 113407 263. 499743 104. 614708 1, 375951 4, 271059 203. 00 Unit cost multiplier (Wkst. B, Part I) 204. 00 Cost to be allocated (per Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 206. 00 NAHE adjustment amount to be allocated 29, 246			0	0		0		194. 05 194. 06
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 1.113407 263.499743 104.614708 1.375951 4.271059 203.00 Cost to be allocated (per Wkst. B, Part II) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated 206.00 NAHE adjustment amount to be allocated 206.00 207.00			10 401	0		20 244		
201.00 Negative Cost Centers 2 2 2 2 2 2 2 2 2	1 1		10, 491	U	1	27, 240	29, 240	200. 00
202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 206.00 NAHE adjustment amount to be allocated		•						201. 00
Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 206.00 NAHE adjustment amount to be allocated Part I) 1. 113407 263. 499743 104. 614708 1. 375951 4. 271059 2 349, 407 2 285, 041 184, 921 629, 651 123, 622 349, 407 2 0. 333642 2			1, 366, 704	4, 609, 401	2, 247, 647	2. 338. 384	4. 472. 875	
203.00 Unit cost multiplier (Wkst. B, Part I) 1.113407 263.499743 104.614708 1.375951 4.271059 2 2 2 2 2 2 2 3 2 2 3 2 3 2 3 2 3 2 3		(po	., 555, 754	., 557, 101		_, 555, 554	., ., 2, 575	
Part II) Unit cost multiplier (Wkst. B, Part 0. 232213 10. 571143 29. 306539 0. 072742 0. 333642 2 11) 206. 00 NAHE adjustment amount to be allocated 2	1 1	t multiplier (Wkst. B, Part I)	1. 113407	263. 499743	104. 614708	1. 375951	4. 271059	203. 00
205.00 Unit cost multiplier (Wkst. B, Part 0.232213 10.571143 29.306539 0.072742 0.333642 2 11) 206.00 NAHE adjustment amount to be allocated 2	204.00 Cost to		1		1	i i		1
206.00 NAHE adjustment amount to be allocated 2		•						
206.00 NAHE adjustment amount to be allocated 2		t multiplier (Wkst. B, Part	0. 232213	10. 571143	29. 306539	0. 072742	0. 333642	205. 00
		uctment amount to be allered to						204 00
								206. 00
1 (100. 11.01. 11		U 2)	1 1		I I			I

Health Financial Systems	HENDRI CKS REG	ONAL HEALTH		In Li∈	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO	CN: 15-0005	Peri od: From 01/01/2017 To 12/31/2017	Worksheet B-1 Date/Time Pre 5/30/2018 4:3	
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERI A (MANHOURS)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	
	8. 00	9. 00	10.00	11. 00	13.00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

				1	o 12/31/2017	Date/lime Prepared: 5/30/2018 4:38 pm
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		SERVICES &	(100%	RECORDS &	/TIME	
		SUPPLY (100%	ALLOCATION)	LI BRARY (GROSS	(TIME SPENT)	
		ALLOCATION)		CHARGES)	SI LIVI)	
		14.00	15. 00	16.00	17. 00	
	ERAL SERVICE COST CENTERS					
1	OO NEW CAP REL COSTS-BLDG & FIXT					1.00
1	OO EMPLOYEE BENEFITS DEPARTMENT OO ADMINISTRATIVE & GENERAL					4.00
1	OO OPERATION OF PLANT					7. 00
	OO LAUNDRY & LINEN SERVICE					8. 00
9.00 009	00 HOUSEKEEPI NG					9. 00
	00 DI ETARY					10.00
1	OO CAFETERI A					11.00
	OO NURSING ADMINISTRATION OO CENTRAL SERVICES & SUPPLY	100				13. 00
	OO PHARMACY	0	100			15. 00
	OO MEDICAL RECORDS & LIBRARY	0	0			16. 00
	00 SOCIAL SERVICE	0	0	0	19, 869	17. 00
	ATIENT ROUTINE SERVICE COST CENTERS	1		0, 100 010		
1	OO ADULTS & PEDIATRICS	0	0			l
	OO INTENSIVE CARE UNIT OO NURSERY	0	0			
	00 SKILLED NURSING FACILITY	0	0	_		
	ILLARY SERVICE COST CENTERS					
	OO OPERATING ROOM	100	0			
	O1 ENDOSCOPY	0	0	_		
1	OO RECOVERY ROOM	0	0	10, 124, 278 0	0	51. 00 52. 00
	00 ANESTHESI OLOGY	0	0	0	0	53.00
1	OO RADI OLOGY-DI AGNOSTI C	0	Ö	22, 228, 227	0	
54. 01 054	01 RADI ATI ON-ONCOLOGY	0	0	0	0	54. 01
	50 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	
	OO CARDI AC CATHETERI ZATI ON	0	0	0	0	
	00 LABORATORY 00 INTRAVENOUS THERAPY	0) 0	56, 961, 679	0	60.00
	00 RESPIRATORY THERAPY	0	0	7, 673, 998		65. 00
	00 PHYSI CAL THERAPY	0	0	4, 598, 409		
1	00 OCCUPATIONAL THERAPY	0	0	1, 314, 134		67. 00
	OO SPEECH PATHOLOGY	0	0	0		
	OO ELECTROCARDI OLOGY O1 CARDI AC REHAB	0	0	5, 998, 071	0	
	OO ELECTROENCEPHALOGRAPHY	0	0	0	0	69. 01 70. 00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	ő	0	71. 00
72. 00 072	OO IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72. 00
	OO DRUGS CHARGED TO PATIENTS	0	100		0	73. 00
	01 ULTRA SOUND	0	0			
	OO RENAL DIALYSIS PATIENT SERVICE COST CENTERS	0	0	0	0	74. 00
90. 00 090		0	0	0	0	90.00
	OO EMERGENCY	0	0			
	OO OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
	CIAL PURPOSE COST CENTERS	100	400	000 044 000	10.0(0	110.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	100	100	229, 341, 030	19, 869	118. 00
	OO PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192. 00
	01 HEALTH TRACKS	0	0			
1	50 PRIMARY CARE CLINIC	0	0	0		
	51 PARTNERS IN CARE	0	0	0		
	152 OCCUPATIONAL MEDICINE 153 FOUNDATION	0	0	0		
	53 FOUNDATION 54 SCHOOL & TOWN CLINICS		0	0	0	
1	55 MANAGED FACILITY		0	0	0	
	56 RENTAL PROPERTIES	0	0	Ō	0	
	57 SNF NON CERTIFIED	0	0	0	0	
200.00	Cross Foot Adjustments					200.00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	2 120 242	E 040 2E1	2 474 751	2 100 500	201. 00 202. 00
202.00	Part I)	3, 120, 263	5, 049, 251	3, 474, 751	3, 108, 598	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	31, 202. 630000	50, 492. 510000	0. 015151	156. 454678	203. 00
204. 00	Cost to be allocated (per Wkst. B,	589, 455				
005.05	Part II)	F 004 5====	0.054.05===			
205. 00	Unit cost multiplier (Wkst. B, Part	5, 894. 550000	2, 856. 070000	0. 001201	5. 831698	205. 00
206. 00	NAHE adjustment amount to be allocated	1				206. 00
	(per Wkst. B-2)					
		·			<u> </u>	<u> </u>

Health Fir	nancial Systems	HENDRI CKS REG	IONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der Co		Peri od: From 01/01/2017	Worksheet B-1	
						Date/Time Pre 5/30/2018 4:3	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		SERVICES &	(100%	RECORDS &			
		SUPPLY	ALLOCATION)	LI BRARY	(TIME		
		(100%		(GROSS	SPENT)		
		ALLOCATION)		CHARGES)			
		14. 00	15. 00	16.00	17. 00		
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10		
Provi der CCN: 15-0005	Peri od: Worksheet C		
	From 01/01/2017 Part		

					o 12/31/2017	Date/Time Pre 5/30/2018 4:3	pared: 8 pm
			Title	XVIII	Hospi tal	PPS	<u> </u>
	·				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	32, 149, 633		32, 149, 633		32, 151, 053	
31. 00	03100 I NTENSI VE CARE UNI T	4, 584, 732		4, 584, 732		4, 584, 732	
43.00	04300 NURSERY	1, 117, 916		1, 117, 916		1, 117, 916	
44.00	04400 SKILLED NURSING FACILITY	0		(0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	16, 133, 778		16, 133, 778	1	16, 133, 778	
50. 01	05001 ENDOSCOPY	2, 543, 897		2, 543, 897		2, 543, 897	
51.00	05100 RECOVERY ROOM	4, 809, 969		4, 809, 969		4, 809, 969	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 867, 364		1, 867, 364		1, 867, 364	
53.00	05300 ANESTHESI OLOGY	2, 029, 934		2, 029, 934		2, 029, 938	
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 365, 332		11, 365, 332		11, 365, 332	
54. 01	05401 RADI ATI ON-ONCOLOGY	24, 020, 138		24, 020, 138		24, 020, 138	
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	544, 219		544, 219		544, 219	
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 884, 594		1, 884, 594		1, 884, 594	1
60.00	06000 LABORATORY	11, 289, 289		11, 289, 289		11, 289, 331	
64. 00	06400 I NTRAVENOUS THERAPY	1, 845, 143		1, 845, 143		1, 845, 143	
65.00	06500 RESPI RATORY THERAPY	4, 938, 610	0	.,		4, 938, 610	
66. 00	06600 PHYSI CAL THERAPY	10, 078, 526	0	, ,		10, 078, 526	
67. 00	06700 OCCUPATI ONAL THERAPY	740, 668	0			740, 668	•
68. 00	06800 SPEECH PATHOLOGY	662, 238	0	,		662, 238	1
69. 00	06900 ELECTROCARDI OLOGY	1, 739, 126		1, 739, 126	0	1, 739, 126	
69. 01	06901 CARDI AC REHAB	1, 147, 117		1, 147, 117		1, 147, 117	
70.00	07000 ELECTROENCEPHALOGRAPHY	429, 825		429, 825		429, 825	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		(0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	7, 024, 537		7, 024, 537		7, 024, 537	
73.00	07300 DRUGS CHARGED TO PATIENTS	17, 851, 535		17, 851, 535		17, 851, 535	
73. 01	07301 ULTRA SOUND	779, 265		779, 265		779, 265	
74.00	07400 RENAL DIALYSIS	234, 066		234, 066	0	234, 066	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	8, 012, 524		8, 012, 524		8, 012, 524	
91. 00	09100 EMERGENCY	12, 537, 458		12, 537, 458		12, 537, 462	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 532, 085		3, 532, 085		3, 532, 085	
200.00		185, 893, 518	0	,		185, 894, 988	
201.00		3, 532, 085		3, 532, 085		3, 532, 085	
202.00	Total (see instructions)	182, 361, 433	0	182, 361, 433	1, 470	182, 362, 903	202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0005	Peri od: Worksheet C
		From 01/01/2017 Part I
		T- 10/01/0017 D-+-/T! D

					o 12/31/2017	Date/Time Prep 5/30/2018 4:38	
			Title	XVIII	Hospi tal	PPS	
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	22, 608, 048		22, 608, 048			30.00
31. 00	03100 INTENSIVE CARE UNIT	5, 626, 916		5, 626, 916	,		31.00
43. 00	04300 NURSERY	6, 439, 564		6, 439, 564			43.00
44. 00	04400 SKILLED NURSING FACILITY	0		C)		44. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	17, 611, 770	30, 181, 872	47, 793, 642	0. 337572	0.000000	50.00
50. 01	05001 ENDOSCOPY	694, 364	9, 571, 169	10, 265, 533	0. 247810	0.000000	50. 01
51. 00	05100 RECOVERY ROOM	2, 986, 972	7, 137, 306	10, 124, 278	0. 475093	0.000000	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	10, 826, 408	166, 647	10, 993, 055	0. 169868	0.000000	52.00
53. 00	05300 ANESTHESI OLOGY	4, 277, 978	6, 901, 329	11, 179, 307	0. 181580	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 362, 295	50, 584, 001	58, 946, 296	0. 192808	0.000000	54. 00
54. 01	05401 RADI ATI ON-ONCOLOGY	738, 565	69, 030, 085	69, 768, 650	0. 344283	0.000000	54. 01
56. 00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	463, 685	4, 211, 873	4, 675, 558	0. 116397	0.000000	56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 300, 438	7, 795, 271	13, 095, 709	0. 143909	0.000000	59. 00
60.00	06000 LABORATORY	11, 819, 672	49, 794, 005	61, 613, 677	0. 183227	0.000000	60.00
64. 00	06400 I NTRAVENOUS THERAPY	68, 885	9, 103, 870	9, 172, 755	0. 201155	0.000000	64.00
65. 00	06500 RESPI RATORY THERAPY	5, 736, 483	7, 252, 160	12, 988, 643	0. 380225	0.000000	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 676, 288	12, 785, 379	14, 461, 667	0. 696913	0.000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	835, 088	962, 040	1, 797, 128	0. 412140	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	421, 446	1, 218, 563	1, 640, 009	0. 403801	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 736, 990	7, 343, 817	10, 080, 807	0. 172519	0.000000	69. 00
69. 01	06901 CARDI AC REHAB	26, 048	2, 439, 260	2, 465, 308	0. 465304	0.000000	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	138, 163	852, 395	990, 558	0. 433922	0.000000	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0.000000	0.000000	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	8, 605, 193	4, 007, 576	12, 612, 769	0. 556939	0.000000	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	10, 463, 164	20, 206, 691	30, 669, 855	0. 582055	0.000000	73. 00
73. 01	07301 ULTRA SOUND	1, 876, 543	10, 662, 384	12, 538, 927	0. 062148	0.000000	73. 01
74. 00	07400 RENAL DIALYSIS	208, 152	6, 331	214, 483	1. 091303	0.000000	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	24, 515	36, 670, 998	36, 695, 513	0. 218352	0.000000	90.00
91. 00	09100 EMERGENCY	16, 557, 344	71, 666, 532	88, 223, 876	0. 142110	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	426, 512	3, 449, 504	3, 876, 016	0. 911267	0.000000	92. 00
200.00	Subtotal (see instructions)	147, 557, 489	424, 001, 058	571, 558, 547	1	ļ	200. 00
201.00	Less Observation Beds					ļ	201. 00
202. 00	Total (see instructions)	147, 557, 489	424, 001, 058	571, 558, 547	1		202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Peri od: Worksheet C From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

			10 12/31/2017	5/30/2018 4:38	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				1	30. 00
31.00 03100 INTENSIVE CARE UNIT				-	31. 00
43. 00 04300 NURSERY					13.00
44.00 O4400 SKILLED NURSING FACILITY				4	14. 00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 337572				50. 00
50. 01 05001 ENDOSCOPY	0. 247810				50. 01
51.00 05100 RECOVERY ROOM	0. 475093				51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 169868			l l	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 181580				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 192808				54. 00
54. 01 05401 RADI ATI ON-ONCOLOGY	0. 344283				54. 01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 116397				56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 143909				59. 00
60. 00 06000 LABORATORY	0. 183228				50. 00
64.00 06400 I NTRAVENOUS THERAPY	0. 201155			6	54. 00
65. 00 06500 RESPI RATORY THERAPY	0. 380225			6	55.00
66. 00 06600 PHYSI CAL THERAPY	0. 696913				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 412140				57. 00
68.00 06800 SPEECH PATHOLOGY	0. 403801				58. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 172519				59. 00
69. 01 06901 CARDI AC REHAB	0. 465304				59. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 433922				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 556939				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 582055				73. 00
73.01 07301 ULTRA SOUND	0. 062148			•	73. 01
74. 00 07400 RENAL DIALYSIS	1. 091303			7	74. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 218352				90.00
91. 00 09100 EMERGENCY	0. 142110				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 911267				92.00
200.00 Subtotal (see instructions)					00.00
201.00 Less Observation Beds				1 -	01.00
202.00 Total (see instructions)				20	02.00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od:	Worksheet C	
		From 01/01/2017		

				rom 01/01/2017 o 12/31/2017	Part I Date/Time Pre 5/30/2018 4:3	pared: 8 pm
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
LANDATI ENT. DOUTENE OFFILIAS OOOT OFFITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	00 440 400		00.440.404		00 151 050	
30. 00 03000 ADULTS & PEDI ATRI CS	32, 149, 633		32, 149, 633		32, 151, 053	
31. 00 03100 I NTENSI VE CARE UNIT	4, 584, 732		4, 584, 732		.,	
43. 00 04300 NURSERY	1, 117, 916		1, 117, 916		1, 117, 916	1
44. 00 04400 SKILLED NURSING FACILITY	0		(0	0	44. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	16, 133, 778		16, 133, 778	Bl ol	16, 133, 778	FO 00
50. 00 05000 OPERATTING ROOM 50. 01 05001 ENDOSCOPY	2, 543, 897		2, 543, 897		2, 543, 897	50. 00 50. 01
51. 00 05100 RECOVERY ROOM	4, 809, 969		4, 809, 969		4, 809, 969	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 867, 364		1, 867, 364		1, 867, 364	
53. 00 05300 ANESTHESI OLOGY	2, 029, 934		2, 029, 934		2, 029, 938	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	11, 365, 332		11, 365, 332		11, 365, 332	
54. 01 05401 RADI ATI ON-ONCOLOGY	24, 020, 138		24, 020, 138		24, 020, 138	
56. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	544, 219		544, 219			56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 884, 594		1, 884, 594		1, 884, 594	
60. 00 06000 LABORATORY	11, 289, 289		11, 289, 289		11, 289, 331	
64. 00 06400 I NTRAVENOUS THERAPY	1, 845, 143		1, 845, 143			
65. 00 06500 RESPIRATORY THERAPY	4, 938, 610	0			4, 938, 610	
66. 00 06600 PHYSI CAL THERAPY	10, 078, 526	0			10, 078, 526	
67. 00 06700 OCCUPATI ONAL THERAPY	740, 668	0	740, 668		740, 668	
68. 00 06800 SPEECH PATHOLOGY	662, 238	0			662, 238	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 739, 126		1, 739, 126		1, 739, 126	69. 00
69. 01 06901 CARDI AC REHAB	1, 147, 117		1, 147, 117	ol	1, 147, 117	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	429, 825		429, 825	o o	429, 825	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	7, 024, 537		7, 024, 537	0	7, 024, 537	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	17, 851, 535		17, 851, 535	5 O	17, 851, 535	73. 00
73.01 07301 ULTRA SOUND	779, 265		779, 265			
74.00 07400 RENAL DIALYSIS	234, 066		234, 066	0	234, 066	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	8, 012, 524		8, 012, 524		8, 012, 524	
91. 00 09100 EMERGENCY	12, 537, 458		12, 537, 458		12, 537, 462	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 532, 085		3, 532, 085		3, 532, 085	
200.00 Subtotal (see instructions)	185, 893, 518	0				
201.00 Less Observation Beds	3, 532, 085	_	3, 532, 085		3, 532, 085	
202.00 Total (see instructions)	182, 361, 433	0	182, 361, 433	1, 470	182, 362, 903	J202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Peri od: From 01/01/2017		

			Ť	o 12/31/2017	Date/Time Pre 5/30/2018 4:3	pared: 8 pm
		Ti tl	e XIX	Hospi tal	Cost	Орш
		Charges	<u> </u>			
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	+ col. 7)	Ratio	I npati ent	
					Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	22, 608, 048		22, 608, 048			30. 00
31.00 03100 INTENSIVE CARE UNIT	5, 626, 916		5, 626, 916			31. 00
43. 00 04300 NURSERY	6, 439, 564		6, 439, 564			43.00
44.00 04400 SKILLED NURSING FACILITY	0		0			44. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	17, 611, 770	30, 181, 872			0.000000	50. 00
50. 01 05001 ENDOSCOPY	694, 364	9, 571, 169	10, 265, 533	0. 247810	0.000000	
51.00 05100 RECOVERY ROOM	2, 986, 972	7, 137, 306	10, 124, 278	0. 475093	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	10, 826, 408	166, 647	10, 993, 055	0. 169868	0.000000	52. 00
53. 00 05300 ANESTHESI OLOGY	4, 277, 978	6, 901, 329	11, 179, 307	0. 181580	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 362, 295	50, 584, 001	58, 946, 296	0. 192808	0.000000	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	738, 565	69, 030, 085	69, 768, 650	0. 344283	0.000000	54. 01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	463, 685	4, 211, 873	4, 675, 558	0. 116397	0.000000	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 300, 438	7, 795, 271	13, 095, 709	0. 143909	0.000000	59. 00
60. 00 06000 LABORATORY	11, 819, 672	49, 794, 005	61, 613, 677	0. 183227	0.000000	60.00
64.00 06400 I NTRAVENOUS THERAPY	68, 885	9, 103, 870	9, 172, 755	0. 201155	0.000000	64. 00
65. 00 06500 RESPI RATORY THERAPY	5, 736, 483	7, 252, 160	12, 988, 643	0. 380225	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 676, 288	12, 785, 379	14, 461, 667	0. 696913	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	835, 088	962, 040	1, 797, 128	0. 412140	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	421, 446	1, 218, 563	1, 640, 009	0. 403801	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 736, 990	7, 343, 817	10, 080, 807	0. 172519	0.000000	69. 00
69. 01 06901 CARDI AC REHAB	26, 048	2, 439, 260	2, 465, 308	0. 465304	0.000000	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	138, 163	852, 395	990, 558	0. 433922	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, 605, 193	4, 007, 576	12, 612, 769		0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	10, 463, 164	20, 206, 691	30, 669, 855	0. 582055	0.000000	73. 00
73.01 07301 ULTRA SOUND	1, 876, 543	10, 662, 384	12, 538, 927	0. 062148	0.000000	73. 01
74. 00 07400 RENAL DIALYSIS	208, 152	6, 331	214, 483	1. 091303	0. 000000	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	24, 515	36, 670, 998			0.000000	
91. 00 09100 EMERGENCY	16, 557, 344	71, 666, 532		0. 142110	0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	426, 512	3, 449, 504	3, 876, 016	0. 911267	0.000000	92.00
200.00 Subtotal (see instructions)	147, 557, 489	424, 001, 058	571, 558, 547			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	147, 557, 489	424, 001, 058	571, 558, 547			202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Peri od: Worksheet C From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared: 5/30/2018 4:38 pm

				10 12/31/2017	5/30/2018 4:3	
			Title XIX	Hospi tal	Cost	ус р
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30. 00
	03100 INTENSIVE CARE UNIT					31. 00
	04300 NURSERY					43. 00
	04400 SKILLED NURSING FACILITY					44. 00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0. 000000				50. 00
	05001 ENDOSCOPY	0. 000000				50. 01
	05100 RECOVERY ROOM	0. 000000				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
	05300 ANESTHESI OLOGY	0. 000000				53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54. 00
	05401 RADI ATI ON-ONCOLOGY	0. 000000				54. 01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000				56. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59. 00
	06000 LABORATORY	0. 000000				60. 00
	06400 I NTRAVENOUS THERAPY	0. 000000				64. 00
	06500 RESPI RATORY THERAPY	0. 000000				65. 00
	06600 PHYSI CAL THERAPY	0. 000000				66. 00
	06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
	06800 SPEECH PATHOLOGY	0. 000000				68. 00
	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
	06901 CARDI AC REHAB	0. 000000				69. 01
	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
	07301 ULTRA SOUND	0. 000000				73. 01
	07400 RENAL DIALYSIS	0. 000000				74. 00
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C	0. 000000				90.00
	09100 EMERGENCY	0.000000				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201. 00
202. 00	Total (see instructions)					202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2017	Part I	
				To 12/31/2017	Date/Time Pre 5/30/2018 4:3	
-		Title	xVIII	Hospi tal	PPS	о ріп
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 601, 508	0	3, 601, 50	8 18, 369	196. 06	30.00
31.00 INTENSIVE CARE UNIT	459, 511		459, 51	1, 809	254. 01	31.00
43. 00 NURSERY	163, 585		163, 58	3, 063	53. 41	43.00
44.00 SKILLED NURSING FACILITY	0			0	0.00	44.00
200.00 Total (lines 30 through 199)	4, 224, 604		4, 224, 60	4 23, 241		200. 00
Cost Center Description	Inpatient	Inpatient		•		
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	6, 690	1, 311, 641				30. 00
31. 00 INTENSIVE CARE UNIT	904	229, 625				31. 00
43. 00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	0	0				44. 00
200.00 Total (lines 30 through 199)	7, 594	1, 541, 266				200. 00

Heal th	Financial Systems	HENDRI CKS REG	IONAL HEALTH		In lie	eu of Form CMS-2	2552_10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	-	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col.	Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		I	1			
50. 00	05000 OPERATING ROOM	1, 329, 201					1
	05001 ENDOSCOPY	235, 754		•			1
51. 00	05100 RECOVERY ROOM	1, 079, 524					1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	241, 340					52. 00
53. 00	05300 ANESTHESI OLOGY	34, 611					1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 199, 236					1
	05401 RADI ATI ON-ONCOLOGY	717, 773					54. 01
56. 00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	23, 078					1
59. 00	05900 CARDI AC CATHETERI ZATI ON	367, 272					1
60.00	06000 LABORATORY	513, 002					
64. 00	06400 I NTRAVENOUS THERAPY	64, 183					64. 00
65. 00	06500 RESPI RATORY THERAPY	477, 633					l
66. 00	06600 PHYSI CAL THERAPY	678, 759	14, 461, 667	0. 04693	908, 529	42, 642	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	64, 353	1, 797, 128	0. 03580	450, 608	16, 136	67. 00
68.00	06800 SPEECH PATHOLOGY	91, 441	1, 640, 009	0. 055756	261, 137	14, 560	68. 00
69. 00	06900 ELECTROCARDI OLOGY	190, 423	10, 080, 807	0. 018890	1, 416, 139	26, 751	69. 00
69. 01	06901 CARDI AC REHAB	177, 251	2, 465, 308	0. 071898	11, 859	853	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	102, 525	990, 558	0. 103502	84, 304	8, 726	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0. 000000	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	39, 292	12, 612, 769	0. 00311!	3, 846, 288	11, 981	72. 00
70.00		0== 044				E (070	1

357, 216

31, 169 1, 771

658, 627

395, 657

1, 112, 953

10, 184, 044

30, 669, 855

12, 538, 927

36, 695, 513

88, 223, 876 3, 876, 016

536, 884, 019

214, 483

0.011647

0.002486

0.008257

0.017948

0.012615

0. 102078

4, 814, 269

8, 620, 919 426, 512

47, 192, 427

953, 418 81, 343 56, 072 73. 00

73. 01

74.00

2, 370

672

0 90.00

108, 753 91. 00

43, 537 92. 00

957, 168 200. 00

73.00 07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

73. 01 07301 ULTRA SOUND

90. 00 09000 CLI NI C

200.00

91.00 09100 EMERGENCY

74.00 07400 RENAL DIALYSIS

Health Financial Systems	HENDRI CKS REG				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider C		Peri od:	Worksheet D	
				From 01/01/2017 To 12/31/2017		nanad.
				10 12/31/2017	Date/Time Pre 5/30/2018 4:3	pareu: 8 nm
		Title	XVIII	Hospi tal	PPS	о рііі
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0	0	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	(0	0	31. 00
43. 00 04300 NURSERY	0	0		0	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0		0		44. 00
200.00 Total (lines 30 through 199)	0	0		0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	18, 369	9 0.00	6, 690	30. 00
31.00 03100 INTENSIVE CARE UNIT		0	1, 809	9 0.00	904	31.00
43. 00 04300 NURSERY		0	3, 063	0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0	(0.00	0	44. 00
200.00 Total (lines 30 through 199)		0	23, 24	1	7, 594	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	0 00					

30. 00 31. 00

43. 00 44. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS
31. 00 03100 INTENSIVE CARE UNIT

43.00 | 04300 | NURSERY 44.00 | 04400 | SKILLED | NURSING FACILITY 200.00 | Total (lines 30 through 199)
 Heal th Financial APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 HENDRICKS REGIONAL HEALTH PROVIDED
 Provider CCN: 15-0005

THROUGH COSTS

						5/30/2018 4: 3	8 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Nursing School	Nursing Schoo	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0	0	50. 00
50. 01	05001 ENDOSCOPY	0	0		0	0	50. 01
51. 00	05100 RECOVERY ROOM	0	0		0 0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54.01	05401 RADI ATI ON-ONCOLOGY	0	0		0 0	0	54. 01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		0 0	0	56. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		o o	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		o o	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		o o	0	69. 00
69. 01	06901 CARDI AC REHAB	0	0		o o	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		o o	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		o o	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		o o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		o o	0	73. 00
73. 01	07301 ULTRA SOUND	0	0		o o	0	73. 01
74.00	07400 RENAL DIALYSIS	0	0		o o	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	0		o o	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			o	0	92.00
200.00	Total (lines 50 through 199)	0	0		0 0	0	200. 00
	, , ,	1		•			•

Health Financial Systems	HENDRICKS REGION	IAL HEALTH	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0005	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2017	

INKOUGH COSTS				o 12/31/2017	Date/Time Prep 5/30/2018 4:38	pared:
		Title	XVIII	Hospi tal	PPS	о ріп
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
	Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col. 2, 3 and	8)	7)	
			4)			
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	C	47, 793, 642	0.000000	50. 00
50. 01 05001 ENDOSCOPY	0	0	C	10, 265, 533	0.000000	50. 01
51.00 05100 RECOVERY ROOM	0	0	C	10, 124, 278	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	10, 993, 055	0.000000	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	C	11, 179, 307	0.000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	58, 946, 296	0.000000	54. 00
54. 01 05401 RADI ATI ON-ONCOLOGY	0	0	C	69, 768, 650	0.000000	54. 01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	C	4, 675, 558	0.000000	56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	C	13, 095, 709	0.000000	59. 00
60. 00 06000 LABORATORY	0	0	C	61, 613, 677	0.000000	60.00
64.00 06400 I NTRAVENOUS THERAPY	0	0	C	9, 172, 755	0.000000	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	C	12, 988, 643	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	C	14, 461, 667	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	1, 797, 128	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	C	1, 640, 009	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	10, 080, 807	0.000000	69.00
69. 01 06901 CARDI AC REHAB	0	0	C	2, 465, 308	0.000000	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	C	990, 558	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	12, 612, 769	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	30, 669, 855	0.000000	73.00
73.01 07301 ULTRA SOUND	0	0	C	12, 538, 927	0. 000000	73. 01
74.00 07400 RENAL DI ALYSI S	0	0	C	214, 483	0. 000000	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	C	36, 695, 513	0.000000	90.00
91. 00 09100 EMERGENCY	0	0	C	88, 223, 876	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	C	3, 876, 016	0. 000000	92. 00
200.00 Total (lines 50 through 199)	0	0	C	536, 884, 019		200. 00
				•	·	-

Heal th	Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10								
	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER'THROUGH COSTS		Provi der Co		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/30/2018 4:3			
		Outpati ent		XVIII	Hospi tal	PPS			
	Cost Center Description		Inpatient Program Charges	Inpatient Program Pass-Through	Outpatient Program Charges	Outpatient Program Pass-Through			
		to Charges (col. 6 ÷ col. 7)	3	Costs (col. x col. 10)		Costs (col. 9 x col. 12)			
		9.00	10.00	11.00	12.00	13. 00			
-	ANCILLARY SERVICE COST CENTERS			•	<u> </u>				
50.00	05000 OPERATI NG ROOM	0. 000000	7, 120, 218		0 8, 891, 561	0	50. 00		
50. 01	05001 ENDOSCOPY	0. 000000	358, 477		0 4, 432, 102	0	50. 01		
51.00	05100 RECOVERY ROOM	0. 000000	1, 013, 031		0 2, 220, 541	0	51.00		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	9, 155		0	0	52. 00		
53.00	05300 ANESTHESI OLOGY	0. 000000	1, 564, 089		0 1, 261, 324	0	53. 00		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	4, 111, 749		0 11, 398, 652	0	54.00		
54.01	05401 RADI ATI ON-ONCOLOGY	0. 000000	305, 856		0 25, 941, 987	0	54. 01		
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000	242, 553		0 1, 755, 593	0	56. 00		
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 657, 822		0 2, 263, 966	0	59. 00		
60.00	06000 LABORATORY	0. 000000	5, 249, 534		0 3, 708, 003	0	60.00		
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	5, 511		0 2, 977, 972	0	64.00		
65.00	06500 RESPI RATORY THERAPY	0. 000000	2, 679, 107		0 1, 276, 563	0	65. 00		
66.00	06600 PHYSI CAL THERAPY	0. 000000	908, 529		0 388, 526	0	66. 00		
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	450, 608		0 11, 046	0	67. 00		
68. 00	06800 SPEECH PATHOLOGY	0. 000000	261, 137		0 21, 851	0	68. 00		
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	1, 416, 139		0 1, 933, 511	0	69. 00		
69. 01	06901 CARDI AC REHAB	0. 000000	11, 859		0 1, 137, 358	0	69. 01		
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	84, 304		0 68, 179	0	70. 00		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	71. 00		
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	3, 846, 288		0 1, 210, 960	0	72. 00		
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	4, 814, 269		0 5, 324, 116	0	73. 00		
72 01	07201 III TDA COUND	0 000000	OE2 410	I	0 2 005 252		72 01		

0. 000000

0. 000000

0.000000

0.000000

0. 000000

4, 814, 269 953, 418 81, 343

8, 620, 919 426, 512

47, 192, 427

3, 005, 253 2, 727

2, 204, 895

13, 660, 286 685, 051

95, 782, 023

0

0

74.00 0

90.00

0 91.00 0 92.00

0 200. 00

0 73. 01

0

73. 01 07301 ULTRA SOUND

91.00 09100 EMERGENCY

200.00

74.00 07400 RENAL DIALYSIS

OUTPATIENT SERVICE COST CENTERS

90. 00 09000 CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0005 Peri od: Worksheet D From 01/01/2017 Part V Date/Time Prepared: 12/31/2017 5/30/2018 4:38 pm Title XVIII Hospi tal Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 337572 8, 891, 561 0 3, 001, 542 50.00 50.01 05001 ENDOSCOPY 0. 247810 4, 432, 102 0 0 1,098,319 50.01 05100 RECOVERY ROOM 0 0 1, 054, 963 51 00 0 475093 2, 220, 541 51 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0.169868 0 0 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0. 181580 1, 261, 324 0 229, 031 53.00 11, 398, 652 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.192808 0 302 2, 197, 751 54.00 05401 RADI ATI ON-ONCOLOGY 0 54.01 0.344283 25, 941, 987 11,575 8, 931, 385 54.01 56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.116397 1, 755, 593 0 204, 346 56.00 05900 CARDIAC CATHETERIZATION 59.00 0.143909 2, 263, 966 0 0 325, 805 59.00 0 679, 406 06000 LABORATORY 3, 708, 003 60 00 60 00 0 183227 84 06400 INTRAVENOUS THERAPY 64.00 0. 201155 2, 977, 972 0 0 599, 034 64.00 06500 RESPIRATORY THERAPY 0.380225 1, 276, 563 0 0 485, 381 65.00 65.00 0 06600 PHYSI CAL THERAPY 0.696913 388, 526 0 270, 769 66.00 66,00 06700 OCCUPATIONAL THERAPY 0 0. 412140 11, 046 4, 552 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0.403801 21, 851 0 0 8,823 68.00 06900 ELECTROCARDI OLOGY 0. 172519 1, 933, 511 69.00 333, 567 69.00 06901 CARDI AC REHAB 1, 137, 358 0 0 529, 217 69.01 0.465304 69.01 0 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0.433922 68, 179 29, 584 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 72.00 0.556939 1, 210, 960 674, 431 72.00 07300 DRUGS CHARGED TO PATIENTS 0 3, 399 73.00 0.582055 5, 324, 116 3, 098, 928 73.00 οĺ 07301 ULTRA SOUND 73.01 0.062148 3,005,253 0 186, 770 73.01 07400 RENAL DIALYSIS 1.091303 0 2, 976 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 0. 218352 2, 204, 895 90.00 09000 CLI NI C 481, 443 90.00 0 0 91.00 09100 EMERGENCY 0.142110 13, 660, 286 0 0 1, 941, 263 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 911267 685, 051 442 624, 264 92.00 200.00 Subtotal (see instructions) 95, 782, 023 526 15, 276 26, 993, 550 200. 00 Less PBP Clinic Lab. Services-Program 201.00 Ω 201.00 Only Charges

95, 782, 023

526

15, 276

26, 993, 550 202. 00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co	CN: 15-0005		Worksheet D Part V Date/Time Prep 5/30/2018 4:38	
		Title	XVIII	Hospi tal	PPS	
Costs		sts				
Cost Center Description	Cost	Cost				

					5/30/2018 4: 3	88 pm
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0				50. 00
50. 01 05001 ENDOSCOPY	o	0				50. 01
51. 00 05100 RECOVERY ROOM	o	0				51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	0				52. 00
53. 00 05300 ANESTHESI OLOGY	o	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	58				54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0	3, 985				54. 01
56. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	o	0				56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	0				59. 00
60. 00 06000 LABORATORY	15	0				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64. 00
65. 00 06500 RESPI RATORY THERAPY	o	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	o	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	o	0				69.00
69. 01 06901 CARDI AC REHAB	o	0				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	0				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	o	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		1, 978				73. 00
73. 01 07301 ULTRA SOUND		0	i			73. 01
74. 00 07400 RENAL DI ALYSI S		0				74. 00
OUTPATIENT SERVICE COST CENTERS	١					1 55
90. 00 09000 CLINIC	O	0				90.00
91. 00 09100 EMERGENCY		0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	403	0				92. 00
200.00 Subtotal (see instructions)	418	6, 021				200.00
201.00 Less PBP Clinic Lab. Services-Program	1 0	0,021				201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	418	6, 021				202. 00
202. 00	1 710	5, 02 1	I			1-52.00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0005	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Preps/30/2018 4:38		
	Title XVIII	Hospi tal	PPS	<u> </u>	
Cost Center Description					

		Title XVIII	Hospi tal	5/30/2018 4: 3 PPS	3 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed days).	vate room days,	18, 369 18, 369 0	1. 00 2. 00 3. 00	
4. 00 5. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room reporting period	r 31 of the cost	16, 351 0	4. 00 5. 00	
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)			0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	0 . 0		6, 690	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	tions)	,	0	10.00
11. 00 12. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)	nter O on this line)	, ,	0	11. 00 12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	3 . 3 .	,	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	0	14. 00		
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	15. 00 16. 00		
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	0.00	17. 00		
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicald rate for swing-bed NF services applicable to services	0.00	19. 00		
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	0.00	20. 00		
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe	32, 151, 053 0	21. 00 22. 00		
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $ 7 \times 1 $ ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		0 32, 151, 053	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges)	lino 29)		0. 000000	30. 00 31. 00
32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 - line 3)	F ITTIE 26)		0.00000	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33. 00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x lin		,	0.00	35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	fferential (line	32, 151, 053	37. 00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 750 00	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 750. 29	38.00
40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		11, 709, 440 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39)			11, 709, 440	

44.00 CORONARY CARE UNIT 45.00 BURN ITRISENIVE CARE UNIT 45.00 BURN ITRISENIVE CARE UNIT 45.00 CORONARY CARE UNIT	Heal th	Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In <u>L</u> ie	eu of Form CMS-2	2552-10		
Cost Center Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C			Worksheet D-1			
Cost Center Description										
Total Program Days Program Day	Ti +l			7 A//111	Hospi tal		8 pm			
1.00 2.00 2.00 2.00 4.00 5.00 6.00		Cost Center Description	Total			-				
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46.00 SIRGICAL INTERISIVE CARE UNIT (7.00 OTHER SPECIAL CARE (SPECIPY) Cost Center Description (1.00										
2.00 Program Inpatient ancillary service cost (West. D.3, col. 3, line 2000) 1.00 1.0								46.00		
1.00	47. 00							47. 00		
44.60, 508 48.00 Program Inpatient ancillary service cost (Misst. D-3, col. 3, line 200) 28.467, 096 48.00 28.467, 096 49.00 Program Inpatient costs (sum of lines 41 through 48) (see Instructions) 28.467, 096 49.00 28.467, 096 49.00 28.467, 096 49.00 28.467, 096 49.00 28.467, 096 49.00 28.467, 096 49.00 28.467, 096 49.00 28.467, 096 49.00 29.00		Cost Center Description					1.00			
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111 51										
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	51. 00		atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	957, 168	51.00		
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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 cost 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) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	70.00						I	70.00		
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74.00 Total Program general inpatient routine Service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Total Program routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 17.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 17.750.29 88.00		, ,			-/			72.00		
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 76.00 Program capital-related costs (line 9 x line 76) 77.00 Inpatient routine service cost (line 74 minus line 77) 80.00 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 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient ancillary services (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total Observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)								73. 00		
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		, ,	•			art II column		1		
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 76.00 77.00 78.00 79.00 80.00 81.00 81.00 82.00 83.00 84.00 85.00 86.00 86.00 87.00 87.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00	75.00		outine Service	CUSIS (II UIII V	IOI NOTICEL D, P	art II, COTUIIII		/3.00		
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 77.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 78.00 Total Program inpatient routine service costs (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		Per diem capital-related costs (line 75 ÷ li						76. 00		
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Robbits of the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 79.00 Robbits minus line 79) 80.00 Robbits minus line 79) 81.00 Robbits minus line 79) 81.00 Robbits minus line 79) 81.00 Robbits minus line 79) 82.00 Robbits minus line 79) 81.00 Robbits minus line 79) 81.00 Robbits minus line 79) 82.00 Robbits minus line 79) 83.00 Robbits minus line 79) 84.00 Robbits minus line 79) 85.00 Robbits minus line 79) 86.00 Robbits minus line 79) 87.00 Robbits minus line 79) 88.00 Robbits minus line 79 88.00 Robbits		, ,								
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Utilization review - physician compensation (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		1 .	,	rovi der record	ls)			1		
82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Reasonable inpatient ancillary services (see instructions) 84.00 Reasonable inpatient on the service costs (see instructions) 84.00 Reasonable inpatient ancillary services (see instructions) 85.00 Reasonable inpatient operation (see instructions) 86.00 Reasonable inpatient operation (see instructions) 87.00 Reasonable inpatient operation (see instructions)				80.00						
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 B8.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 B8.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 B8.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine servic										
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 84.00 85.00 86.00 86.00 86.00				* .				1		
85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		•		<u>-,</u>				84. 00		
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,750.29 88.00		5.00 Utilization review - physician compensation (see instructions)								
87.00 Total observation bed days (see instructions) 2,018 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,750.29 88.00	86. 00									
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,750.29 88.00	87. 00						2. 018	87. 00		
89.00 Observation bed cost (line 87 x line 88) (see instructions) 3,532,085 89.00	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 750. 29	88. 00		
	89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				3, 532, 085	89.00		

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH	L HEALTH In Lieu of Form CMS-2			2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/30/2018 4:3	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	3, 601, 508	32, 151, 053	0. 11201	8 3, 532, 085	395, 657	90.00
91.00 Nursing School cost	0	32, 151, 053	0.00000	0 3, 532, 085	0	91.00
92.00 Allied health cost	0	32, 151, 053	0.00000	0 3, 532, 085	0	92.00
93.00 All other Medical Education	0	32, 151, 053	0.00000	0 3, 532, 085	0	93. 00

Health Financial Systems	In Li∈	eu of Form CMS-	2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0005	Peri od: From 01/01/2017	Worksheet D-1	
			Date/Time Pre 5/30/2018 4:3	
	Title XIX	Hospi tal	Cost	
Cost Center Description				

		Ti +l o VI V	Hospi tal	5/30/2018 4: 38	8 pm
	Cost Center Description	Title XIX	Hospi tal	Cost	
	oost ochter beschiptron			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS			10.040	
1.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			18, 369	1.00
2. 00 3. 00	Private room days (excluding swing-bed and observation bed day	<i>y</i> ,	ivato room dave	18, 369 0	2. 00 3. 00
3.00	do not complete this line.	ys). It you have only pr	i vate i ooiii days,	١	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		16, 351	4.00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room		21 -6 +1+	0	7 00
7. 00	reporting period	ii days) through beceiliber	31 Of the Cost	ا	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	m davs) after December 3	1 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)	,]	
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	310	9. 00
	newborn days)			_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	o	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er		oom days) arter	ا	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12.00
	through December 31 of the cost reporting period	3 .	,		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14.00	after December 31 of the cost reporting period (if calendar ye				14 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	2 063	14. 00 15. 00
	Nursery days (title V or XIX only)			3,003	
10.00	SWING BED ADJUSTMENT			0	10.00
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
10.00	reporting period	- +b	414	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			32, 149, 633	
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a ported (line 6	o	23. 00
23.00	x line 18)	31 of the cost reporting	g period (Title o	١	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)	·	5 1		
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
24 00	x line 20) Total swing-bed cost (see instructions)				24 00
26. 00 27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		0 32, 149, 633	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Title 21 millias Title 20)		32, 147, 033	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		0 ,	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nue line 33)/coo inctruo	tions)	0. 00 0. 00	1
34. 00 35. 00	Average per diem private room cost differential (line 34 x lin		LI UIIS)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	32, 149, 633	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 750. 21	
39. 00	Program general inpatient routine service cost (line 9 x line	•		542, 565	ı
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 542, 565	40.00
71.00	Trotal Trogical general impatrent routine service cost (ITIIe 37	11110 40)		542, 505	1 -1.00

	Financial Systems	HENDRI CKS REG			In Lie	eu of Form CMS-2		
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co		Period: From 01/01/2017	Worksheet D-1		
					Γο 12/31/2017	Date/Time Pre	pared:	
			Ti +I	e XIX	Hospi tal	5/30/2018 4:3 Cost	8 pm	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost		
	·	Inpatient Cost	Inpatient Days		+	(col. 3 x col.		
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00		
42. 00	NURSERY (title V & XIX only)	1, 117, 916					42. 00	
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4, 584, 732	1, 809	2, 534. 40	0	0		
44. 00 45. 00	CORONARY CARE UNIT						44. 00 45. 00	
46. 00							46.00	
	OTHER SPECIAL CARE (SPECIFY)						47. 00	
	Cost Center Description					1.00		
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	R line 200)			1. 00 308, 758	48. 00	
	Total Program inpatient costs (sum of lines			ns)		851, 323	1	
	PASS THROUGH COST ADJUSTMENTS	<u>.</u>				1		
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	0	50.00	
51. 00	<pre> </pre>	atient ancillar	y services (fr	om Wkst. D. si	ım of Parts II	0	51.00	
	and IV)		J	2, 3,				
52.00	Total Program excludable cost (sum of lines		alatad '	ololo: !	.+! a+	0		
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		erated, non-phy	sician anesthe	erist, and	0	53. 00	
	TARGET AMOUNT AND LIMIT COMPUTATION	/					1	
	Program di scharges					0		
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1	
57. 00	, ,	ing cost and ta	arget amount (I	ine 56 minus I	ine 53)	0	1	
58. 00	Bonus payment (see instructions)	Ü			ŕ	0	58. 00 59. 00	
59. 00								
60. 00	market basket 10 Lesser of Lines 53/54 or 55 from prior year cost report, updated by the market basket							
61. 00	If line 53/54 is less than the lower of line				the amount by	0.00	1	
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							
62 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	0	62. 00					
	Allowable Inpatient cost plus incentive paym	Ö						
	PROGRAM INPATIENT ROUTINE SWING BED COST					1		
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of the	cost reportir	ng period (See	0	64. 00	
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the c	ost reporting	period (See	0	65. 00	
	instructions)(title XVIII only)							
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66.00	
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31 o	f the cost re	ortina period	0	67. 00	
	(line 12 x line 19)	Ü		·	0 .			
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost repor	rting period	0	68. 00	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	68)		0	69.00	
	PART III - SKILLED NURSING FACILITY, OTHER N							
70.00	Skilled nursing facility/other nursing facil	,					70.00	
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /0 ÷ line	2)			71.00	
73. 00	Medically necessary private room cost applic		n (line 14 x li	ne 35)			73.00	
74. 00	Total Program general inpatient routine serv	•					74. 00	
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	e costs (from W	orksheet B, Pa	art II, column		75. 00	
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00	
77. 00	Program capital -related costs (line 9 x line	,					77. 00	
	Inpatient routine service cost (line 74 minu			->			78.00	
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				ıs line 79)		79. 00 80. 00	
81. 00	Inpatient routine service costs for comp			(1110 /0 111110	///		81.00	
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	· * .				82. 00	
83.00	Reasonable inpatient routine service costs (ns)				83.00	
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00	
	Total Program inpatient operating costs (sum						86.00	
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST				1		
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2			2, 018 1, 750. 21	1	
	Observation bed cost (line 87 x line 88) (se	•				3, 531, 924		

Health Financial Systems HENDRICKS REGIONAL HEAL				In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/30/2018 4:3	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	3, 601, 508	32, 149, 633	0. 11202	3, 531, 924	395, 657	90.00
91.00 Nursing School cost	0	32, 149, 633	0.00000	3, 531, 924	0	91.00
92.00 Allied health cost	o	32, 149, 633	0.00000	3, 531, 924	0	92.00
93.00 All other Medical Education	o	32, 149, 633	0.00000	3, 531, 924	0	93.00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0005	Peri od:	Worksheet D-3	
				From 01/01/2017 To 12/31/2017	Data /Tima Dwa	
				10 12/31/2017	Date/Time Pre 5/30/2018 4:3	pared: 8 pm
		Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	-
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	_
30. 00	03000 ADULTS & PEDIATRICS			7, 847, 704		30.0
31. 00	03100 INTENSIVE CARE UNIT			2, 717, 583		31. 0
	04300 NURSERY			2, 717, 303		43. 0
+3.00	ANCI LLARY SERVI CE COST CENTERS					1 43.0
50.00	05000 OPERATI NG ROOM		0. 3375	72 7, 120, 218	2, 403, 586	50.0
50. 01	05001 ENDOSCOPY		0. 2478			
1. 00	05100 RECOVERY ROOM		0. 4750		481, 284	1
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 1698			1
3. 00	05300 ANESTHESI OLOGY		0. 1815	·		1
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1928			1
4. 01	05401 RADI ATI ON-ONCOLOGY		0. 3442			
6. 00	03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 1163			
9. 00	05900 CARDI AC CATHETERI ZATI ON		0. 1439			
0.00	06000 LABORATORY		0. 1832			
4. 00	06400 I NTRAVENOUS THERAPY		0. 2011		1, 109	64. 0
5. 00	06500 RESPI RATORY THERAPY		0. 3802		1, 018, 663	
6. 00	06600 PHYSI CAL THERAPY		0. 6969	13 908, 529	633, 166	66. (
7. 00	06700 OCCUPATI ONAL THERAPY		0. 4121	40 450, 608	185, 714	67. (
8. 00	06800 SPEECH PATHOLOGY		0. 4038	01 261, 137	105, 447	68.0
9. 00	06900 ELECTROCARDI OLOGY		0. 1725	1, 416, 139	244, 311	69. (
9. 01	06901 CARDI AC REHAB		0. 4653	04 11, 859	5, 518	69. (
0.00	07000 ELECTROENCEPHALOGRAPHY		0. 4339	22 84, 304	36, 581	70.0
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	00	0	71. (
2.00	07200 I MPL. DEV. CHARGED TO PATIENT		0. 5569	39 3, 846, 288	2, 142, 148	72. (
3.00	07300 DRUGS CHARGED TO PATIENTS		0. 5820	55 4, 814, 269	2, 802, 169	73. 0
3. 01	07301 ULTRA SOUND		0. 0621		59, 253	73. (
4. 00	07400 RENAL DI ALYSI S		1. 0913	03 81, 343	88, 770	74. (
	OUTPATIENT SERVICE COST CENTERS					4
	09000 CLI NI C		0. 2183		1	
1. 00	09100 EMERGENCY		0. 1421			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 9112			
00.00			[47, 192, 427		
201.00		s (line 61)		0	l	201. (
202.00	Net charges (line 200 minus line 201)		1	47, 192, 427		202.

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCI		Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 4:3	pared: 8 pm
	Title		Hospi tal	Cost	
Cost Center Description		Ratio of Cos ⁻		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			284, 284		30.00
31. 00 03100 I NTENSI VE CARE UNI T			34, 760		31.00
43. 00 04300 NURSERY			208, 548		43.00
ANCI LLARY SERVI CE COST CENTERS		0 22757	154 400	F0.4F0	
50. 00 05000 0PERATI NG ROOM 50. 01 05001 ENDOSCOPY		0. 33757		52, 152	
50. 01 05001 ENDOSCOPY 51. 00 05100 RECOVERY ROOM		0. 24781 0. 47509			
52. 00 05100 RECOVERY ROOM ST. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 47509		9, 603 56, 939	
53. 00 05300 ANESTHESI OLOGY		0. 18158			
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 19280		13, 838	
54. 01 05401 RADI OLOGY		0. 14280			
56. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 11639			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 14390		0	
60. 00 06000 LABORATORY	•	0. 18322		34, 009	
64. 00 06400 I NTRAVENOUS THERAPY		0. 20115			
65. 00 06500 RESPI RATORY THERAPY		0. 38022		21, 067	
66. 00 06600 PHYSI CAL THERAPY		0. 69691		5, 892	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 41214		1, 621	
68. 00 06800 SPEECH PATHOLOGY		0. 40380		672	
69. 00 06900 ELECTROCARDI OLOGY		0. 17251		9, 502	
69. 01 06901 CARDI AC REHAB		0. 46530		160	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 43392		418	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 55693		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 58205	5 110, 039	64, 049	73.00
73. 01 07301 ULTRA SOUND		0. 06214	8 21, 080	1, 310	73. 01
74. 00 07400 RENAL DI ALYSI S		1. 09130	3, 626	3, 957	74.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 21835	2 0	0	90.00
91 00 09100 EMERGENCY	I	0 1/211	0 157 9/19	22 422	01 00

0. 142110 0. 911267

91. 00 92. 00

202. 00

22, 432 0

308, 758 200. 00 201. 00

157, 848

1, 241, 596

91. 00 09100 EMERGENCY

200.00 201.00 202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 4:38 pm

-		Title XVIII	Hospi tol	5/30/2018 4: 38	8 pm
		TI LIE AVIII	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 1. 01	DRG amounts other than outlier payments for discharges occurring instructions)	prior to October 1 (s	see	0	1. 00
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	g on or after October	l (see	17, 114, 615	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	discharges occurring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCl for October 1 (see instructions)	discharges occurring	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			407, 880 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction	ns)		0	2. 02
3.00	Managed Care Simulated Payments			0	3. 00
4. 00	Bed days available divided by number of days in the cost reporti Indirect Medical Education Adjustment	ng period (see instru	ctions)	121. 47	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most r or before 12/31/1996. (see instructions)	recent cost reporting p	period ending on	0. 00	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the for new programs in accordance with 42 CFR 413.79(e)	e criteria for an add-o	on to the cap	0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified und ACA § 5503 reduction amount to the IME cap as specified under 42			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopathi affiliated programs in accordance with 42 CFR 413.75(b), 413.79(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 slots	s under § 5503 of the A	ACA. If the cost	0. 00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots	s from a closed teachi	ng hospital	0. 00	8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see				9. 00
10. 00	<pre>instructions) FTE count for allopathic and osteopathic programs in the current</pre>	year from your record	ds	0. 00	10. 00
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0. 00 0. 00	11. 00 12. 00
13. 00	Total allowable FTE count for the prior year.			0. 00	
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sep	tember 30, 1997,	0. 00	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.				15. 00
16.00	Adjustment for residents in initial years of the program			0.00	
17. 00	Adjustment for residents displaced by program or hospital closur	-e			17. 00
18. 00	Adjusted rolling average FTE count			0.00	
19. 00 20. 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	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22. 00	IME payment adjustment (see instructions)			0.000000	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422 c	of the MMA			
23. 00	Number of additional allopathic and osteopathic IME FTE resident $(f)(1)(iv)(C)$.	cap slots under 42 Cl	FR 412. 105	0. 00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0. 00	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the low	wer of line 23 or line	24 (see	0. 00	25. 00
26. 00	Instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0.000000	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pati	ent days (see instruct	tions)	1. 67	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)				31.00
32. 00	Sum of lines 30 and 31			18. 57	32.00
	Allowable disproportionate share percentage (see instructions)			4. 82	
34.00	Disproportionate share adjustment (see instructions)			206, 231	34.00

	Financial Systems HENDRICKS REGIO ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	Peri od:	Worksheet E	2552-1
			From 01/01/2017 To 12/31/2017	Part A Date/Time Pre	
		Title XVIII	Hospi tal	5/30/2018 4: 3: PPS	8 pm
		II the Aviii	Prior to 10/1		
			1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		0	0] 35. 00
35. 00 35. 01	Factor 3 (see instructions)		0. 000000000	0. 000000000	
35. 02	Hospital uncompensated care payment (If line 34 is zero, ent	er zero on this line) (s		1, 087, 014	
25 02	instructions)	nount (oog i notrugti ong)	410 (50	272 007	25 0
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment am Total uncompensated care (sum of columns 1 and 2 on line 35.		412, 659 686, 646	273, 987	35. 00 36. 00
	Additional payment for high percentage of ESRD beneficiary d				
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding	discharges for MS-DRGs	0		40. 0
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683 684 an 685 (see	0		41.00
11.00	instructions)	000, 001 411 000. (300			11.0
41. 01	1 3	5-DRGs 652, 682, 683, 68	4 0		41.0
42. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6				43. 0
	instructions)	•			
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44.00
45. 00	Average weekly cost for dialysis treatments (see instruction	is)	0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 4	1. 01)	0		46.00
47. 00	Subtotal (see instructions)	!	18, 415, 372		47. 0
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural nospitals	0		48. 00
	1 (000 That dott only)		'	Amount	
10.00		`		1.00	40.0
49. 00 50. 00	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L, Pt. I a)	18, 415, 372 1, 500, 672	
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt		,	0	51. 0
52. 00	Direct graduate medical education payment (from Wkst. E-4, I	ine 49 see instructions)	i e	0	52. 0
53.00	Nursing and Allied Health Managed Care payment			0	53.0
54. 00 54. 01	Special add-on payments for new technologies Islet isolation add-on payment			0	54. 0 54. 0
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	ı
56. 00	Cost of physicians' services in a teaching hospital (see int	•		0	56. 0
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	57.0
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	IV, col. 11 line 200)		0 19, 916, 044	
60.00	Primary payer payments			11, 041	ı
61. 00	Total amount payable for program beneficiaries (line 59 minu	s line 60)		19, 905, 003	1
62. 00	Deductibles billed to program beneficiaries			2, 043, 132	1
63.00	Coinsurance billed to program beneficiaries			27, 965	
64.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			190, 858 124, 058	1
66. 00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		190, 858	1
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		17, 957, 964	67.0
58. 00	Credits received from manufacturers for replaced devices for		,	0	68.0
59. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	.(For SCH see instruction	ns)	0	69.0
70. 50	Rural Community Hospital Demonstration Project (§410A Demons	tration) adjustment (see	instructions)	0	70. C
70. 87	Demonstration payment adjustment amount before sequestration		2 2 2 2 2 3 3 3 3 3	0	1
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 8
70. 89	Pioneer ACO demonstration payment adjustment amount (see ins	tructions)		2	70.8
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	1
	Bundled Model 1 discount amount (see instructions)			0	70. 9
70. 92				-	ı
70. 92 70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			87, 063 -79, 788	

Health Finar	ncial Systems	HENDRICKS REGION	AL HEALTH		In Lie	u of Form CMS-	2552-10
CALCULATI ON	OF REIMBURSEMENT SETTLEMENT		Provi der Co	CN: 15-0005	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/30/2018 4:3	epared:
			Title	: XVIII	Hospi tal	PPS	о р
					(уууу)	Amount	
					0	1. 00	
	volume adjustment for federal fisc		n column 0		0	0	70. 96
70. 97 Low v	corresponding federal year for the olume adjustment for federal fisc corresponding federal year for the	cal year (yyyy) (Enter i			0	0	70. 97
	/olume Payment-3	o por roa onaring on or ar	,			0	70. 98
	adjustment amount (see instruction	ns)				0	70. 99
	nt due provider (line 67 minus lin		59 & 70)			17, 965, 239	71.00
	estration adjustment (see instruc		•			359, 305	71. 01
	nstration payment adjustment amoun					0	1
72. 00 Inter	im payments	•				17, 583, 876	72.00
73.00 Tenta	ative settlement (for contractor u	use only)				0	73.00
74. 00 Bal ai 73)	nce due provider/program (line 71	minus lines 71.01, 71.0	2, 72, and			22, 058	74.00
CMS I	ested amounts (nonallowable cost models)		nce with			199, 017	75. 00
	COMPLETED BY CONTRACTOR (lines 9			T		_	4
	ating outlier amount from Wkst. E,		tructions)			0	70.00
	tal outlier from Wkst. L, Pt. I, I					0	1
	ating outlier reconciliation adjus					0	1 /2.00
	tal outlier reconciliation adjustr					0	1
	rate used to calculate the time value of manay for apprehing aver-		uctions)			0. 00 0	
	value of money for operating expenses		tions)			0	
96. 00 11 lile	value of money for capital relate	ed expenses (see Instruc	ti ons)		Prior to 10/1	On/After 10/1	96.00
					1.00	2. 00	_
HSD F	onus Payment Amount				1.00	2.00	
	oonus amount (see instructions)				0	0	100.00
	Adjustment for HSP Bonus Payment					<u> </u>	1.00.00
	adjustment factor (see instruction	ons)			0.0000000000	0.0000000000	1101 00
	adjustment amount for HSP bonus		5)		0		102.00
	djustment for HSP Bonus Payment		,				
	adjustment factor (see instruction	ns)			0.0000	0.0000	103.00
	adjustment amount for HSP bonus pa)		0		104.00
	Community Hospital Demonstration			stment			1
200.00 Is th	nis the first year of the current	5-year demonstration per	riod under t	he 21st			200. 00
	ury Cures Act? Enter "Y" for yes o Reimbursement	or "N" for no.					
201. 00 Medi	care inpatient service costs (from	m Wkst. D-1, Pt. II, lind	e 49)				201. 00
202. 00 Medi	care discharges (see instructions))					202.00
203. 00 Case	-mix adjustment factor (see instru	uctions)					203. 00
Compu	tation of Demonstration Target An	mount Limitation (N/A in	first year	of the currer	nt 5-year demonst	ration	1
peri c							4
	care target amount						204. 00
DOE OULCOSS	mily adjusted taxast amount (line	202 times line 204)			1		lane or

205. 00 206. 00

207. 00

208. 00

209. 00 210. 00 211. 00

212. 00 213. 00 218. 00

205.00 Case-mix adjusted target amount (line 203 times line 204)

209.00 Adjustment to Medicare IPPS payments (see instructions)

(line 212 minus line 213) (see instructions)

213.00 Low-volume adjustment (see instructions)

210.00 Reserved for future use

206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement

211.00 Total adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

207.00 Program reimbursement under the §410A Demonstration (see instructions)

208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)

218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

Provider CCN: 15-0005

W.S. E., Part A. Amounts (From Pre/Post Period Prior Particul Particul Total (Col 2 1.00				T: +1 -	WILL I	11: +-1	5/30/2018 4: 3	8 pm
11		W/S F Part A	Amounts (from			Hospi tal Peri od	PPS Total (Col. 2	
1.00 DRG amounts other than outlier 1.00 0 0 0 0 0 0 0 0 0								
Dayments				2.00	3. 00	4. 00		1 00
1.01 ORG amounts other than outlier 1.01 O O O O O O O O O		1.00	0	O	0	0	0	1. 00
DRC amounts other than outlier payments for discharges occurring on or after October 1 1.03	1.01 DRG amounts other than outlier payments for discharges	1. 01	О	0	0		0	1. 01
Operating payment for Model 4 BRCI occurring prior to October 1 Octobe	1.02 DRG amounts other than outlier payments for discharges	1. 02	17, 114, 615	0		17, 114, 615	17, 114, 615	1. 02
1.04	operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
2.00	1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1. 04
2.01	2.00 Outlier payments for	2. 00	407, 880	0	0	407, 880	407, 880	2. 00
3.00 Operating outlier 2.01 0 0 0 0 0 0 0 0 0	2.01 Outlier payments for	2. 02	0	0	0	0	0	2. 01
Managed care simulated 3.00 0 0 0 0 0 0 0 0 0	3.00 Operating outlier	2. 01	0	0	0	0	0	3. 00
Indirect Medical Education Adjustment	4.00 Managed care simulated	3. 00	0	0	0	0	0	4. 00
A.	Indirect Medical Education Adj							
6.00 IME payment adjustment (see 22.00 0 0 0 0 0 0 0	•	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
IME payment adjustment for 22.01	6.00 IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
Instructions Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA IME payment adjustment factor (see instructions) IME payment adjustment factor (see instructions) IME adjustment (see 28.00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	6.01 IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate share percentage (see instructions) Share Adjustment (see instructions) Share Adjustment (see instructions) Outlines (see ins	instructions)	etmont for the	Add on for Son	stion 122 of t	ho MMA			
8.00 ME adjustment (see 28.00 0 0 0 0 0 0 0 0 0	7.00 IME payment adjustment factor					0. 000000		7. 00
8.01 IME payment adjustment add on for managed care (see instructions) 9.00 Total IME payment (sum of 29.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00 IME adjustment (see	28. 00	0	0	0	0	0	8. 00
9.00 Total IME payment (sum of lines 6 and 8) 9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) 0 0 0 0 0 0 0 0 0	8.01 IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8. 01
9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share adjustment 10.00 Disproportionate share ercentage (see instructions) 11.00 Disproportionate share adjustment 33.00 0.0482	9.00 Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
Di sproporti onate Share Adjustment	9.01 Total IME payment for managed care (sum of lines 6.01 and	29. 01	O	0	0	0	0	9. 01
10. 00								
Share percentage (see instructions)			0. 0482	0. 0482	0. 0482	0. 0482		10.00
11.00 Disproportionate share	share percentage (see	30.00	3. 3.32	0.0102	0.0.02	0.0.02		10.00
11.01 Uncompensated care payments 36.00 686,646 0 412,659 273,987 686,646 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment 46.00 0 0 0 0 0 0 (see instructions) 47.00 18,415,372 0 412,659 18,002,713 18,415,372 14.00 Hospital specific payments 48.00 0 0 0 0 0 0 0 0 0	11.00 Di sproporti onate share	34.00	206, 231	0	0	206, 231	206, 231	11. 00
12.00 Total ESRD additional payment (see instructions) 46.00 0 0 0 0 0 0 13.00 Subtotal (see instructions) 47.00 18,415,372 0 412,659 18,002,713 18,415,372 14.00 Hospital specific payments 48.00 0 0 0 0 0	11.01 Uncompensated care payments				412, 659	273, 987	686, 646	11. 01
13.00 Subtotal (see instructions) 47.00 18,415,372 0 412,659 18,002,713 18,415,372 14.00 Hospital specific payments 48.00 0 0 0 0	12.00 Total ESRD additional payment				0	0	0	12. 00
(completed by SCH and MDH,	13.00 Subtotal (see instructions)		18, 415, 372 0	0	412, 659 0	18, 002, 713 0	18, 415, 372 0	13. 00 14. 00
Small rural hospitals only.) (see instructions)	small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see	49. 00	18, 415, 372	0	412, 659	18, 002, 713	18, 415, 372	15. 00
capital (from Wkst. L, Pt. I,	16.00 Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	1, 500, 672	0	О	1, 500, 672	1, 500, 672	16. 00
	17.00 Special add-on payments for	54. 00	0	0	0	0	0	17. 00
new technologies 17.01 Net organ aquisition cost 17.02 Credits received from 68.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17.01 Net organ aquisition cost 17.02 Credits received from manufacturers for replaced		o	0	0	0	0	17. 01 17. 02

Heal th	Financial Systems		HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-	2552-10
LOW VOL	LUME CALCULATION EXHIBIT 4			Provi der C		Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/30/2018 4:3	pared:
				Title	: XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1. 00	2. 00	3.00	4. 00	5. 00	
	Capital outlier reconciliation adjustment amount (see	93. 00	0	0		0 0	0	18. 00

	·	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01	through 4)	
		0	1. 00	2.00	3. 00	4. 00	5. 00	
18.00	Capital outlier reconciliation	93.00	0	0	0	0	0	18. 00
	adjustment amount (see							
	instructions)							
19. 00	SUBTOTAL			0	412, 659	19, 503, 385	19, 916, 044	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, 395, 704	0	0	1, 395, 704	1, 395, 704	
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	0	0	0	20. 01
	than outlier			_	_			
21. 00	Capital DRG outlier payments	2. 00	51, 513	0	0	51, 513	51, 513	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	0	0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0000	0. 0000	0.0000	0. 0000		22. 00
	percentage (see instructions)		_	_	_	_	_	
23. 00	Indirect medical education	6. 00	0	0	0	0	0	23. 00
	adjustment (see instructions)	40.00						
24. 00	Allowable disproportionate	10. 00	0. 0383	0. 0383	0. 0383	0. 0383		24. 00
	share percentage (see							
	instructions)	44.00	50 455					
25. 00	Di sproporti onate share	11. 00	53, 455	0	0	53, 455	53, 455	25. 00
0/ 00	adjustment (see instructions)	40.00	4 500 (70			4 500 (70	4 500 (70	0, 00
26.00	Total prospective capital	12. 00	1, 500, 672	0	0	1, 500, 672	1, 500, 672	26.00
	payments (see instructions)	W/C F D I A	(A					
		W/S E, Part A						
		line 0	Part A) 1.00	2. 00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor	U	1.00	2.00	0.000000	0. 000000	5.00	27. 00
28. 00	Low volume adjustment ractor	70. 96			0.000000	0.00000	0	
20.00	(transfer amount to Wkst. E,	70. 70			0		U	20.00
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				0	0	29. 00
29.00	(transfer amount to Wkst. E,	70. 77				Ü	U	29.00
	Pt. A, line)							
100 00	Transfer low volume		Υ					100. 00
100.00	adjustments to Wkst. E, Pt. A.		'					100.00
	adjustments to wast. E, Ft. A.	ı		l	I	l	ı	ı

 Heal th Financial
 Systems
 HENDRICKS REGION

 HOSPITAL
 ACQUIRED
 CONDITION (HAC)
 REDUCTION CALCULATION EXHIBIT 5
 HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 Peri od: Worksheet E From 01/01/2017 To 12/31/2017 Part A Exhi bit 5 Date/Time Prepared: 5/30/2018 4:38 pm Provi der CCN: 15-0005

			T: +1 o	VVIII	Haani tal	5/30/2018 4: 38	3 pm
		Wks+ F D+		XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt.	Period to 10/01	Peri od on after 10/01	Total (cols. 2 and 3)	
		A, TITIE	A)	10/01	arter 10/01	allu 3)	
		0	1.00	2.00	3. 00	4. 00	
1.00	DRG amounts other than outlier payments	1.00	1.00	2.00	5. 00	4.00	1. 00
1. 01	DRG amounts other than outlier payments for	1. 01	0	n		0	1. 01
1.01	di scharges occurring prior to October 1	1.01		Ŭ		ĭ	1.01
1. 02	DRG amounts other than outlier payments for	1. 02	17, 114, 615		17, 114, 615	17, 114, 615	1. 02
1.02	di scharges occurring on or after October 1	1.02	17, 114, 013		17, 114, 013	17, 114, 015	1. 02
1. 03	DRG for Federal specific operating payment	1. 03	0	0		0	1. 03
1.00	for Model 4 BPCI occurring prior to October	1.00	Ĭ	Ĭ		ĭ	1.00
	1						
1.04	DRG for Federal specific operating payment	1. 04	0		0	ol	1. 04
	for Model 4 BPCI occurring on or after						
	October 1						
2.00	Outlier payments for discharges (see	2. 00	407, 880	0	407, 880	407, 880	2.00
	instructions)		·				
2.01	Outlier payments for discharges for Model 4	2. 02	0	0	0	o	2. 01
	BPCI						
3.00	Operating outlier reconciliation	2. 01	0	0	0	o	3.00
4.00	Managed care simulated payments	3. 00	0	0	0	o	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0.000000	0.000000		5.00
	(see instructions)						
6.00	IME payment adjustment (see instructions)	22. 00	O	0	0	o	6.00
6.01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	6. 01
	instructions)						
	Indirect Medical Education Adjustment for the	Add-on for Se	ection 422 of t	he MMA			
7.00	IME payment adjustment factor (see	27. 00	0. 000000	0.000000	0.000000		7.00
	instructions)						
8.00	IME adjustment (see instructions)	28. 00	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed	28. 01	0	0	0	0	8. 01
	care (see instructions)						
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01	0	0	0	0	9. 01
	lines 6.01 and 8.01)						
	Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage	33. 00	0. 0482	0. 0482	0. 0482		10.00
	(see instructions)						
11. 00	Di sproporti onate share adjustment (see	34.00	206, 231	0	206, 231	206, 231	11. 00
	instructions)	0, 00					
11. 01	Uncompensated care payments	36.00	686, 646	412, 659	273, 987	686, 646	11.01
40.00	Additional payment for high percentage of ESF		di scharges		0		40.00
12. 00	Total ESRD additional payment (see	46. 00	0	0	0	0	12. 00
12 00	instructions)	47.00	10 415 272	410 (50	10 000 710	10 415 272	12 00
13.00	Subtotal (see instructions)	47. 00 48. 00	18, 415, 372	412, 659	18, 002, 713	18, 415, 372	
14. 00	Hospital specific payments (completed by SCH	48.00	U	U	U	0	14. 00
	and MDH, small rural hospitals only.) (see						
15. 00	instructions) Total payment for inpatient operating costs	49. 00	10 /15 272	412 450	18, 002, 713	10 /15 272	15 00
15.00	(see instructions)	49.00	18, 415, 372	412, 659	10, 002, 713	18, 415, 372	13.00
16. 00		50. 00	1, 500, 672	0	1, 500, 672	1, 500, 672	16 00
16.00	Payment for inpatient program capital (from	30.00	1, 300, 672	U	1, 300, 672	1, 500, 672	10.00
17. 00	Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies	54.00	0	_	0	0	17. 00
17. 00	Net organ acquisition cost	54.00	١	ا	U	۷	17. 00
17. 01	Credits received from manufacturers for	68. 00		_	0	0	
17.02	replaced devices for applicable MS-DRGs	00.00	١		U	ا	17.02
18. 00	Capital outlier reconciliation adjustment	93. 00	0	_	Ō	0	18. 00
10.00	amount (see instructions)	73.00			U	۷	10.00
19. 00	SUBTOTAL			412, 659	19, 503, 385	19, 916, 044	19 00
	1	I	ı	112,007	. , , 555, 565	. , , , 10, 044	

Heal th	Financial Systems	HENDRI CKS REG	IONAL HEALTH		In Lie	u of Form CMS-:	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5		F	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/30/2018 4:3	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, 395, 704	(1, 395, 704	1, 395, 704	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	51, 513	(51, 513	51, 513	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0. 0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	(0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0383	0. 0383	0. 0383		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	53, 455	(53, 455	53, 455	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	1, 500, 672	(1, 500, 672	1, 500, 672	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	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	87, 063	(87, 063	87, 063	30. 00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-79, 788		-79, 788	-79, 788	31.00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0	(0	0	31. 01

0

70. 99

1.00

Ν

0

3. 00

2.00

0 32. 00

(Amt. to Wkst. E, Pt. A) 4.00

100. 00

instructions)

32.00 HAC Reduction Program adjustment (see

instructions)

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

Health Financial Systems	S HENDRICKS REGIONAL HEALTH I			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/30/2018 4:38 pm	

			10 12/31/201/	5/30/2018 4:3	pared 8 nm		
		Title XVIII	Hospi tal	PPS	о ріп		
				1. 00			
00	PART B - MEDICAL AND OTHER HEALTH SERVICES			(420	1 , ,		
. 00 . 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)	tions)		6, 439 26, 993, 550			
. 00	OPPS payments	ti ons)		18, 985, 994	1		
. 00	Outlier payment (see instructions)			252, 913	1		
. 01	Outlier reconciliation amount (see instructions)						
. 00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000			
. 00	Line 2 times line 5	•		0	6.0		
. 00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.0			
. 00	Transitional corridor payment (see instructions)		0	8. 0			
. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	0					
0. 00	Organ acqui si ti ons			0			
1. 00	Total cost (sum of lines 1 and 10) (see instructions)			6, 439	11. (
	COMPUTATION OF LESSER OF COST OR CHARGES				-		
2 00	Reasonable charges Ancillary service charges			15, 802	12.0		
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		15, 802	1		
	Total reasonable charges (sum of lines 12 and 13)	1116 07)		15, 802	1		
1. 00	Customary charges			10,002	1		
5. 00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	15.0		
6. 00	Amounts that would have been realized from patients liable for			0	1		
	had such payment been made in accordance with 42 CFR §413.13(e)					
7. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	1		
	Total customary charges (see instructions)			15, 802			
9. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	9, 363	19. (
0. 00	instructions)	lv if line 11 evenede li	no 10) (coo	0	20.		
0.00	Excess of reasonable cost over customary charges (complete onlinstructions)	Ty IT TITLE IT exceeds IT	ne ro) (see	0	20.1		
1. 00	Lesser of cost or charges (see instructions)			6. 439	21.		
	Interns and residents (see instructions)	0					
	Cost of physicians' services in a teaching hospital (see instr	0	23.				
4. 00	0 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)						
	COMPUTATION OF REIMBURSEMENT SETTLEMENT						
	Deductibles and coinsurance (for CAH, see instructions)			0			
6.00	Deductibles and Coinsurance relating to amount on line 24 (for		221 /	3, 687, 917	1		
7. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) prinstructions)	orus the sum of fines 22	and 23] (See	15, 557, 429	27.		
8. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 50)		0	28.		
9. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	29.		
	Subtotal (sum of lines 27 through 29)			15, 557, 429	1		
1. 00	Primary payer payments			4, 298	31.		
2. 00	Subtotal (line 30 minus line 31)			15, 553, 131	32.		
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	CES)		ı			
	Composite rate ESRD (from Wkst. I-5, line 11)			0			
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			183, 737			
	Allowable bad debts for dual eligible beneficiaries (see inst	suctions)		119, 429 183, 737			
	Subtotal (see instructions)	detrons)		15, 672, 560			
8. 00	MSP-LCC reconciliation amount from PS&R			-42			
9. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1		
9. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39.		
9. 97					39.		
9. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39.		
9. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.				
0. 00	Subtotal (see instructions)		15, 672, 602 313, 452				
0. 01							
0. 02							
	Interim payments Tentative settlement (for contractors use only)				41.		
2. 00 3. 00	31				42. 43.		
4. 00							
1. 00	\$115. 2	iso wi tii oms rub. 13-2,	chapter 1,	0	44.		
	TO BE COMPLETED BY CONTRACTOR				1		
0. 00	Original outlier amount (see instructions)			0	90.		
1. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.		
2. 00							
	Time Value of Money (see instructions)			0	93.		
3. 00	Total (sum of lines 91 and 93)			0	94.		

In Lieu of Form CMS-2552-10

| Period: | Worksheet E-1 |
| From 01/01/2017 | Part |
| To 12/31/2017 | Date/Time Prepared: | 5/30/2018 4:38 pm Health Financial Systems HEND ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0005

Interin 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 1						5/30/2018 4: 38	3 pm
1.00			Title	XVIII	Hospi tal	PPS	
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			Inpatien	t Part A	Par	rt B	
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
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.				2.00		4. 00	
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	1. 00	Total interim payments paid to provider		17, 525, 701		15, 236, 260	1. 00
Write "NONE" or enter a zero	2. 00	submitted or to be submitted to the contractor for		C		0	2. 00
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write in North in		write "NONE" or enter a zero					
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3. 00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provider ADJUSTMENTS TO PROVIDER 12/31/2017 58, 175 12/31/2017 151, 459 3. 01 3. 02 3. 03 3. 04 3. 05 3. 04 3. 05 3. 04 3. 05 3. 04 3. 05 3. 04 3. 05							
ADJUSTMENTS TO PROVIDER					1		
3.02 3.03 3.04 0 0 3.02 3.03 3.04 0 0 3.03 3.04 3.05	3 01		12/31/2017	58 175	12/31/2017	151 459	3 01
3. 03 0 0 0 0 3. 03 3. 04 3. 05 0 0 0 0 3. 03 3. 05 0 0 0 0 3. 05 3. 50 3. 51 0 0 0 0 3. 51 3. 51 0 0 0 0 3. 52 3. 52 0 0 0 3. 53 3. 53 0 0 0 3. 53 3. 54 0 0 0 3. 53 3. 50 3. 50 3. 50 3. 50 3. 50 3. 50 3. 50 3. 50 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) 17, 583, 876 151, 459 3. 99 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) 17, 583, 876 15, 387, 719 5. 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) Frogram to Provider TENTATIVE TO PROGRAM 0 0 0 5. 02 5. 01 TENTATIVE TO PROGRAM 0 0 0 5. 55 5. 50 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 0 0 0 5. 59 5. 00 Determined net settlement amount (balance due) based on the cost report. (1) 0 0 0 0 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 0 0 0 0 6. 01 SETLEMENT TO PROGRAM 0 0 0 0 6. 02 SETLEMENT TO PROGRAM 0 0 0 0 7. 00 Total Medicare program liability (see instructions) 0 0 0 0 7. 00 Total Medicare program liability (see instructions) 0 0 0 0 7. 00 Total Medicare program liability (see instructions) 0 0 0 0 7. 00 Total Medicare program liability (see instructions) 0 0 0 0 7. 00 Total Medicare program liability (see instructions) 0 0 0 0 7. 00 Total Medicare program liability (see instructions) 0 0 0 0 7. 00 Total Medicare program liability (see instructions) 0 0 0 0 7. 00 Total Medicare program liability (see instructions) 0 0 0 0 7. 00 Total Medicare program liability (see instructions) 0 0 0 0 0 7. 00 Total Medicare program liability (see instructions) 0 0 0 0 0 7. 00 Total Medicare pro		ABSOSTMENTS TO TROVIDER	127 0 17 20 17				
3.04 0 0 0 3.04 3.05 Provider to Program							
3. 55							
3. 50 ADJUSTMENTS TO PROGRAM							3. 05
3.51 3.52 0		Provider to Program					
3.52 3.53 3.54 3.99 3.50 3.53 3.50 3.50 3.53 3.50	3.50	ADJUSTMENTS TO PROGRAM		C)	0	3. 50
3.53 3.54 3.59 3.50-3.98 3.50-3.	3.51			C)	0	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 151,459 3.99 17,583,876 151,459 3.99 17,583,876 15,387,719 4.00 17,583,876 15,387,719 4.00 17,583,876 15,387,719 4.00 17,583,876 15,387,719 4.00 17,583,876 15,387,719 4.00 17,583,876 15,387,719 4.00 17,583,876 15,387,719 4.00 17,583,876 15,387,719 4.00 15,387,719 4							3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 151,459 3.99 17,583,876 151,459 3.99 17,583,876 15,387,719 4.00 101 interim payments (sum of lines 1, 2, and 3.99) 17,583,876 15,387,719 4.00 15,387,719						1	3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) 17,583,876 15,387,719 4.00						1	
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3. 99			58, 175	5	151, 459	3. 99
appropriate	4.00	Total interim payments (sum of lines 1, 2, and 3.99)		17, 583, 87 <i>6</i>		15, 387, 719	4.00
TO BE COMPLETED BY CONTRACTOR							
5.00 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							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Write "NONE" or enter a zero. (1) Program to Provider S. 01 TENTATIVE TO PROVIDER O	5.00						5. 00
Program to Provider							
TENTATI VE TO PROVIDER		Program to Provider					
5.02 0	5 01)	0	5 01
Solution Solution		TENTITIVE TO TROVIDEN					5. 02
Provider to Program							5. 03
TENTATI VE TO PROGRAM 0		Provider to Program			•	-	
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 5.59	5.50	TENTATI VE TO PROGRAM		C)	0	5. 50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 22, 058 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 28, 569 6. 02 7. 00 Total Medicare program liability (see instructions) 17, 605, 934 15, 359, 150 7. 00 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	5.51			C		0	5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				()	- 1	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 22,058 0 6.01 28,569 6.02 17,605,934 15,359,150 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99	,		(0	5. 99
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 22,058 0 6.01 28,569 6.02 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6. 00	Determined net settlement amount (balance due) based on					6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 28, 569 6.02 17, 605, 934 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6. 01			22. 058	3	o	6. 01
7.00 Total Medicare program liability (see instructions) 17,605,934 15,359,150 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00						- 1	6. 02
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00							7. 00
0 1.00 2.00					Contractor	NPR Date	
			()			
	8. 00	Name of Contractor					8. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	Peri od: Worksheet E-3 From 01/01/2017 Part VII To 12/31/2017 Date/Time Prepared: E/20/2018 4.38 pm

			10 12/31/201/	5/30/2018 4:3	
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		851, 323		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)		851, 323	0	
5.00	Inpatient primary payer payments		101, 642		5. 00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		749, 681	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges		T		
8. 00	Routine service charges		527, 592	_	8. 00
9.00	Ancillary service charges		1, 241, 596	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		1 7/0 100	0	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		1, 769, 188	0	12. 00
13. 00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for	s corvi cos on a chargo	0	0	13.00
13.00	basis	services on a charge	0	U	13.00
14. 00	Amounts that would have been realized from patients liable for	navment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 4			O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 011 3110. 10(0)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		1, 769, 188	0	
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	917, 865	0	17. 00
	line 4) (see instructions)	,			
18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
20. 00	Cost of physicians' services in a teaching hospital (see instr		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		851, 323	0	21. 00
00.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide			00.00
	Other than outlier payments		0	0	
23. 00 24. 00	Outlier payments		0	Ü	23. 00 24. 00
25. 00	Program capital payments Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	1
27. 00	Subtotal (sum of lines 22 through 26)		0	0	1
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		851, 323	0	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		001,020		27.00
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))	749, 681	0	
32.00	Deducti bl es		0	0	32. 00
33.00				0	33. 00
34.00				0	34. 00
35.00					35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			0	36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
38. 00				0	
39. 00					39. 00
40.00				0	
41. 00	1.3			0	
42. 00	Balance due provider/program (line 40 minus line 41)		82, 298	0	
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		I

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

Health Financial Systems

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

Provi der CCN: 15-0005

Peri od: Worksheet G From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 4:38 pm

——————————————————————————————————————					5/30/2018 4:3	8 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
4 00	CURRENT ASSETS	4 550 454	T		1	1 4 00
1. 00 2. 00	Cash on hand in banks Temporary investments	4, 553, 151	0	_	_	1. 00 2. 00
3.00	Notes receivable				0	3.00
4. 00	Accounts receivable	101, 147, 263	1	0	ő	4. 00
5.00	Other recei vabl e	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-64, 360, 659	0	0	0	6. 00
7. 00	Inventory	3, 026, 170	0	0	0	7. 00
8.00	Prepai d expenses	0 700 740	0	0	0	8. 00
9. 00 10. 00	Other current assets Due from other funds	39, 729, 743	0	_	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	84, 095, 668	1	_		11.00
11.00	FIXED ASSETS	01,070,000	,			11.00
12.00	Land	0	0	0	0	12.00
13. 00	Land improvements	0	0	0		13. 00
14. 00	Accumulated depreciation	0	0	_	_	14. 00
15. 00	Buildings	0	0	0	0	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	44, 108, 460		0	0	16. 00 17. 00
18. 00	Accumul ated depreciation	1 44, 108, 400		_	0	18.00
19. 00	Fi xed equipment	403, 745, 882	1	_	ő	19.00
20. 00	Accumulated depreciation	-188, 733, 388	1	0	Ō	20.00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	0	0	0	0	23. 00
24. 00	Accumulated depreciation	0	0	0	0	24. 00
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation			0	0	25. 00 26. 00
27. 00	HIT designated Assets			0	o o	27. 00
28. 00	Accumulated depreciation	0	Ö	Ō	Ō	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	259, 120, 954	0	0	0	30. 00
04 00	OTHER ASSETS	T 0/F 004 400		_		1 04 00
31. 00 32. 00	Investments Penerits on Leases	265, 004, 122	0	_	_	31. 00 32. 00
33. 00	Deposits on Leases Due from owners/officers			_	0	33.00
34. 00	Other assets	22, 059, 724	1	_	ő	34.00
35. 00	Total other assets (sum of lines 31-34)	287, 063, 846			Ō	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	630, 280, 468	0	0	0	36. 00
	CURRENT LIABILITIES	1			1	
37. 00	Accounts payable	23, 007, 547	1		_	37. 00
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	12, 561, 698	0	0	0	38. 00 39. 00
40. 00	Notes and Loans payable (short term)			0	0	40.00
41. 00	Deferred income			0	ő	41.00
42. 00	Accel erated payments	0		_		42.00
43.00	Due to other funds	1, 040, 415	0	0	0	43. 00
44. 00	Other current liabilities	14, 982, 802		_	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	51, 592, 462	2 0	0	0	45. 00
44 00	LONG TERM LIABILITIES	1 0	0	0	1 0	1 44 00
46. 00 47. 00	Mortgage payable Notes payable			_	_	46. 00 47. 00
48. 00	Unsecured Loans			_		48. 00
49. 00	Other long term liabilities	173, 928, 371				49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	173, 928, 371		0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	225, 520, 833	0	0	0	51.00
	CAPITAL ACCOUNTS	1			1	
52. 00	General fund balance	404, 759, 635				52.00
53. 00	Specific purpose fund		0	0		53. 00 54. 00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant		1		0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on		1			
59. 00	Total fund balances (sum of lines 52 thru 58)	404, 759, 635	1	0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	630, 280, 468	0	0	0	60.00
	· · /	I	I	l	I	I

Provider CCN: 15-0005

					То	12/31/2017	Date/Time Prep 5/30/2018 4:38	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1.00	2.00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period		391, 238, 581			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		13, 521, 067 404, 759, 648			0		2. 00 3. 00
4.00	Additions (credit adjustments) (specify)	o	404, 737, 040		0	0	0	4. 00
5. 00	(apart)	o			0		Ō	5. 00
6.00		0			0		0	6. 00
7.00		0			0		0	7. 00
8. 00 9. 00		0			0		0	8. 00 9. 00
10. 00	Total additions (sum of line 4-9)	٩	0		U	0		10.00
11. 00	Subtotal (line 3 plus line 10)		404, 759, 648			0		11. 00
12.00	ROUNDI NG	13			0		0	
13. 00		0			0		0	13. 00
14. 00 15. 00		0			0		0	14. 00 15. 00
16. 00					0			16. 00
17. 00		o			O		Ö	17. 00
18.00	Total deductions (sum of lines 12-17)		13			0		18. 00
19. 00	Fund balance at end of period per balance		404, 759, 635			0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
	I -	6. 00	7. 00	8. 00				
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0			1. 00 2. 00
3.00	Total (sum of line 1 and line 2)	اه			0			3. 00
4. 00	Additions (credit adjustments) (specify)		0					4. 00
5.00			0					5. 00
6.00			0					6. 00
7. 00 8. 00			0					7. 00 8. 00
9. 00			0					9. 00
10. 00	Total additions (sum of line 4-9)	o	J		0			10. 00
11. 00	Subtotal (line 3 plus line 10)	o			0			11. 00
12.00	ROUNDI NG		0					12.00
13. 00 14. 00			0					13. 00 14. 00
15. 00			0					15. 00
16. 00			0					16. 00
17. 00			0					17. 00
18.00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)				0			19. 00
	ionas (iiio ii minas iiio io)	ı I		ı	1			

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

		1	o 12/31/2017	Date/Time Pre 5/30/2018 4:3	
	Cost Center Description	Inpati ent	Outpati ent	Total	Э ріп
	0000 0001001 00001 pt 1 011	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	29, 047, 612		29, 047, 612	1. 00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY			0	7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	29, 047, 612	2	29, 047, 612	10. 00
	Intensive Care Type Inpatient Hospital Services			F (0) 01/	
11.00	INTENSIVE CARE UNIT	5, 626, 916		5, 626, 916	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14. 00 15. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)				14. 00 15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	5, 626, 916		5, 626, 916	16. 00
10.00	11-15)	3, 020, 910]	5, 626, 916	16.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	34, 674, 528		34, 674, 528	17. 00
18. 00	Ancillary services	102, 871, 136		422, 723, 372	18. 00
19. 00	Outpatient services	16, 581, 859		128, 795, 405	19. 00
20. 00	RURAL HEALTH CLINIC	10,001,00		0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		-	0	21. 00
22. 00	HOME HEALTH AGENCY			_	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26. 00
27.00	PRIMARY CARE CLINIC		722, 133	722, 133	27. 00
27. 01	OCCUPATI ONAL MEDI CI NE		1, 002, 655	1, 002, 655	27. 01
27. 02	SCHOOL AND TOWN CLINICS		1, 415, 888	1, 415, 888	27. 02
27. 03	PROFESSI ONAL FEES	4, 975, 799	60, 230, 628	65, 206, 427	27. 03
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	159, 103, 322	495, 437, 086	654, 540, 408	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		294, 167, 497		29. 00
30.00	ADD (SPECIFY)	(30.00
31. 00					31.00
32.00					32.00
33.00					33.00
34.00					34. 00 35. 00
35. 00 36. 00	Total additions (sum of lines 30-35)		, O		36. 00
37. 00	DEDUCT (SPECIFY)		_		37. 00
38. 00	DEDUCT (SPECITI)				38. 00
39. 00					39. 00
40. 00					40. 00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)		n		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	er	294, 167, 497		43. 00
	to Wkst. G-3, line 4)				
		*	· '		

	Financial Systems HENDRICKS REGIO			u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-0005	Peri od:	Worksheet G-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	nared·
			10 12/01/201/	5/30/2018 4: 3	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			654, 540, 408	1. 00
2.00	Less contractual allowances and discounts on patients' accou	nts		381, 899, 767	2. 00
3.00	Net patient revenues (line 1 minus line 2)			272, 640, 641	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		294, 167, 497	
5.00	Net income from service to patients (line 3 minus line 4)			-21, 526, 856	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			25, 967, 663	
7. 00	Income from investments			0	
8.00	Revenues from telephone and other miscellaneous communicatio	n servi ces		0	
9.00	Revenue from television and radio service			0	,, 00
10.00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			0	
12. 00	Parking lot receipts			0	
13. 00	Revenue from Laundry and Linen service			0	
14. 00	Revenue from meals sold to employees and guests			15, 810	
15. 00	Revenue from rental of living quarters				15. 00
16. 00	Revenue from sale of medical and surgical supplies to other	than patients			16. 00
17. 00	Revenue from sale of drugs to other than patients				17. 00
18. 00	Revenue from sale of medical records and abstracts			0	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00				9, 064, 450	
	Total other income (sum of lines 6-24)			35, 047, 923	
	Total (line 5 plus line 25)			13, 521, 067	
	OTHER EXPENSES (SPECIFY)			0	
28 00	Total other evenese (sum of line 27 and subscripts)			Λ	28 00

28.00

13, 521, 067 29. 00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

	<i>y</i>	EGIONAL HEALTH		u of Form CMS-2	2552-10
CALCU	LATION OF CAPITAL PAYMENT	Provi der CCN: 15-0005	Peri od: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Pre 5/30/2018 4:3	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				1
1. 00	Capital DRG other than outlier			1, 395, 704	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			51, 513	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions) Number of interns & residents (see instructions)			50. 47 0. 00	
4. 00 5. 00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			0.00	
0. 00	1.01) (see instructions)	The sum of Tries I and I. of	, corumns r and	O	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Pari	t A patient days (Worksheet E	, part A line	1. 67	7.00
	30) (see instructions)		•		
8. 00	Percentage of Medicaid patient days to total days (see in	nstructions)		16. 90	
9. 00	Sum of lines 7 and 8			18. 57	
10.00		tions)		3. 83	
11.00				53, 455	
12. 00	Total prospective capital payments (see instructions)			1, 500, 672	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instruction			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	
5.00	Total Theatrent program capital cost (Title 3 x Title 4)			0	3.00
				1. 00	
4 60	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)	stances (oss instruction)		0	
2.00	Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2)	,		0	
2 00	The program ripatrent capital costs (Trie 1 milius rine 2,	1		0. 00	
	Applicable exception percentage (see instructions)				4.00
4.00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	1			5 00
4. 00 5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	
4. 00 5. 00 6. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se	ee instructions)	(line 6)		6.00
4. 00 5. 00 6. 00 7. 00	Capital cost for comparison to payments (line 3 x line 4)	ee instructions)	(line 6)	0 0. 00	6. 00 7. 00
4. 00 5. 00 6. 00 7. 00 8. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi	ee instructions) nary circumstances (line 2 >	(line 6)	0 0. 00 0	6. 00 7. 00 8. 00
4.00 5.00 6.00 7.00 8.00 9.00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (so Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level	ee instructions) nary circumstances (line 2 > applicable) to capital payments (line 8	less line 9)	0 0.00 0 0	6. 00 7. 00 8. 00 9. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Capital cost for comparison to payments (line 3 x line 4). Percentage adjustment for extraordinary circumstances (so Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7). Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level or Worksheet L, Part III, line 14)	ee instructions) nary circumstances (line 2 > applicable) to capital payments (line 8 ver capital payment (from pri	less line 9) or year	0.00 0.00 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Capital cost for comparison to payments (line 3 x line 4). Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7). Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level or Worksheet L, Part III, line 14). Net comparison of capital minimum payment level to capital	ee instructions) nary circumstances (line 2 > applicable) to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus lir	less line 9) or year ne 11)	0.00 0.00 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Capital cost for comparison to payments (line 3 x line 4). Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7). Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level or Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, etc.)	ee instructions) nary circumstances (line 2 > applicable) to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus lirenter the amount on this line	less line 9) or year ne 11)	0.00 0.00 0 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Capital cost for comparison to payments (line 3 x line 4). Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7). Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level or Worksheet L, Part III, line 14). Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, coarryover of accumulated capital minimum payment level or carryover of accumulated capital minimum payment level or carryover of accumulated capital minimum payment level or carryover.	ee instructions) nary circumstances (line 2 > applicable) to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus lirenter the amount on this line	less line 9) or year ne 11)	0.00 0.00 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (set Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ow Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level ow (if line 12 is negative, enter the amount on this line)	ee instructions) nary circumstances (line 2 > applicable) to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus line enter the amount on this line ver capital payment for the f	less line 9) or year ne 11)	0.00 0.00 0 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
4.00	Capital cost for comparison to payments (line 3 x line 4). Percentage adjustment for extraordinary circumstances (set Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7). Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level comparison of capital minimum payment level on Worksheet L, Part III, line 14). Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, carryover of accumulated capital minimum payment level of (if line 12 is negative, enter the amount on this line). Current year allowable operating and capital payment (see	ee instructions) nary circumstances (line 2 > applicable) to capital payments (line 8 //er capital payment (from prival payments (line 10 plus line enter the amount on this line //er capital payment for the fee instructions)	less line 9) or year ne 11)	0.00 0.00 0 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00