This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0030 Worksheet S Peri od: From 01/01/2017 Parts I-III AND SETTLEMENT SUMMARY 12/31/2017 Date/Time Prepared: 5/30/2018 9:14 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically filed cost report Date: 5/30/2018 9:14 am use only ] Manually submitted cost report ] 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. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

## PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HENRY COUNTY MEMORIAL HOSPITAL (15-0030) 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)
	, ,
Title	<b>}</b>
B . I .	
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	-117, 559	-72, 928	0	29, 059	1.00
2.00	Subprovi der – IPF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	0	0		0	3.00
4.00	SUBPROVI DER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	NEW CASTLE FAMILY & INTERNAL MED	0		919, 066		0	10.00
10.01	NCFIM- NORTHFIELD PARK II	0		40, 343		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	-117, 559	886, 481	0	29, 059	200.00
	ovo amounts roprosont "duo to" or "duo from"	the applicable			the above compl		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.

From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 9:13 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1000 NORTH 16TH STREET 1.00 PO Box: 1.00 City: NEW CASTLE State: IN 2.00 Zi p Code: 47392 County: HENRY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 HENRY COUNTY MEMORIAL 150030 99915 07/01/1996 N 0 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - 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 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA HCMH HOME CARE 157430 99915 06/14/1995 N Ρ Ν 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce HOSP-BASED HOSPICE 151564 99915 14.00 08/31/1998 14.00 NEW CASTLE FAMILY AND Hospital-Based Health Clinic - RHC O 15.00 158520 99915 04/11/2017 N 0 15.00 NTERNAL MED Hospital-Based Health Clinic - RHC NCFIM - NORHTFIELD PARK 158525 99915 15.01 12/04/2017 0 15.01 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: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2017 12/31/2017 20.00 Type of Control (see instructions) 9 21.00 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 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 22.01 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 N 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 in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N 22.03 Ν 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. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 Ν 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 enter "Y" for yes or used in the prior cost reporting period? In column 2, "N" for no. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d Medi cai d paid days el i gi bl e Medi cai d days unpai d paid days el i gi bl e unpai d days 1. 00 3. 00 5. 00 2. 00 4.00 6.00 24.00 If this provider is an IPPS hospital, enter the 137 0 24.00 1. 081 461 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

	Financial Systems HENRY COUNTY ME TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		<u>HOSPITAL</u> Provider CC	:N: 15-0030	Pei	ri od:	In Li			CMS-2 et S-2	
00111	AL AND HOST ME NEIGHT ONE COME EEX TEENT TO AN ON BANK	ľ	rovi dei oc	N. 10 0000		om 01/0	1/201 1/201	7 Par 7 Dat	t I e/Tin	ne Pre 18 9:1	pared
	In-S Medic paid	cai d days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	St Med eli un	t-of tate i cai d gi bl e pai d	Medi HMO	cai d days	Otl Medi da	her cai d ıys	J dill
5. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	2.00	3.00		. 00	5.	0		00	25. (
					-	Urban/R 1.0		S Dat	e of 2.00		1
6. 00	Enter your standard geographic classification (not wage) s cost reporting period. Enter "1" for urban or "2" for rura		at the be	ginning of	the			1			26.0
7. 00	Enter your standard geographic classification (not wage) s reporting period. Enter in column 1, "1" for urban or "2" enter the effective date of the geographic reclassification	status for r	ural. If a		st			1			27. (
5. 00	If this is a sole community hospital (SCH), enter the numble effect in the cost reporting period.			CH status i	n			0			35.0
	periods.					Begi nr			Endi n 2. 00		
6. 00	Enter applicable beginning and ending dates of SCH status.	Subs	cript line	36 for num	ber	1. (			۷. ۵۱	,	36.0
7. 00	of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the	numbe	r of perio	ds MDH stat	us			1			37.
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH accordance with FY 2016 OPPS final rule? Enter "Y" for yes										37.
3. 00	<pre>instructions) If line 37 is 1, enter the beginning and ending dates of M greater than 1, subscript this line for the number of peri enter subsequent dates.</pre>					01/01/	/2017	12	2/31/2	2017	38.
					-	Y/ 1. (			Y/N 2. 00		
9. 00	Does this facility qualify for the inpatient hospital paym hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (for yes or "N" for no. Does the facility meet the mileage with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "\instructions)	(ii)? requi	Enter in c rements in	olumn 1 "Y" accordance		Y			Υ Υ	,	39.
0. 00	Is this hospital subject to the HAC program reduction adju "N" for no in column 1, for discharges prior to October 1. no in column 2, for discharges on or after October 1. (see	Ente	r "Y" for			N			N		40.
							1.	_	. 00	XI X 3. 00	
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment for	dien	roportiona	to share in	200	ordanco	:   1		N	N	45.
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L,	for	extraordi n	ary circums	tanc	es	י		N	N	46.
7. 00 3. 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS capital Is the facility electing full federal capital payment? Er	nl? E	nter "Y fo	r yes or "N	l" fo	Ü	1		N N	N N	47. 48.
5. 00	Teaching Hospitals Is this a hospital involved in training residents in appro	ved G	ME program	s? Enter "	Y" f	or yes		1			56.
7. 00	or "N" for no. If line 56 is yes, is this the first cost reporting period GME programs trained at this facility? Enter "Y" for yes	or "N	" for no i	n column 1.	Ιf	col umn					57.
	is "Y" did residents start training in the first month of for yes or "N" for no in column 2. If column 2 is "Y", co "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if	mplet appli	e Workshee cable.	t E-4. If c	ol um	n 2 is					F0
	If line 56 is yes, did this facility elect cost reimbursen defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete the cost of the c	ete W	kst. D-5.		.es a	5					58.
9.00	Are costs claimed on line 100 of Worksheet A? If yes, com	<u>ірі ете</u>	WKST. D-2	, Pt. 1. NAHE 413.8 Y/N	85	Worksh Li ne		Pas Qua	ss-Thr lific riter Code	ation ion	59.
	Are you claiming nursing and allied health education (NAHE			1. 00 N		2. (	00		3. 00		60.

HOSPI T	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provi der C		Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/30/2018 9:1	
		Y/N	IME	Direct GME	I ME	Direct GME	
		1.00	2. 00	3. 00	4. 00	5. 00	
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. 01
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
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. 04
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. 05
61. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		N				61.06
		Pro	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3. 00	4. 00	
	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.  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		61. 10
						1.00	
	ACA Provisions Affecting the Health Resources and Se	rvi ces <i>l</i>	ıdmi ni strati o	n (HRSA)		1. 00	
62. 00	Enter the number of FTE residents that your hospital				riod for which	0.00	62.00
62. 01	your hospital received HRSA PCRE funding (see instructions and instructions) for the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression of the progre	a Teachi gram. (s	ee instructio		o your hospital	0.00	62. 01
63. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this o	cost reporting 67. (see inst	period? Enter ructions)	N	63. 00
				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
	lo			1.00	2. 00	3. 00	
64. 00	Section 5504 of the ACA Base Year FTE Residents in Neperiod that begins on or after July 1, 2009 and before Enter in column 1, if line 63 is yes, or your facilities in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in	re June ty train n-primar all non d non-pr	30, 2010. ed residents y care provider imary care	-This base yea			64.00
	of (column 1 divided by (column 1 + column 2)). (see						

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0030 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 9:13 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + FTEs FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if li is yes, or your facility 0.000000 65.00 0.00 0. 00 if line 63 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/ (col. 1 + col. 2)) FTEs in FTFs Hospi tal Nonprovi der Si te 2. 00 3. 00 1 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. FTEs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5. 00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 N Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N"

76.00	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or no. Column 2: Did this facility train residents in a new teaching program in accordance	"N" for		76.00
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y,			
	indicate which program year began during this cost reporting period. (see instructions)			
			1. 00	
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81. 00	Is this a LTCH co-located within another hospital for part or all of the cost reporting	period? Enter	N	81.00
	"Y" for yes and "N" for no. TEFRA Provi ders			
85. 00		or "N" for no.	N	85.00
86. 00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section			86.00
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
	1000(d)(1)(b)(VI)? EIILEI 1 TOI YES OI N TOI 110.	V	XIX	
		1. 00	2. 00	
	Title V and XIX Services			
90. 00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Υ	90.00
01 00	yes or "N" for no in the applicable column.  Is this hospital reimbursed for title V and/or XIX through the cost report either in	N	N	91.00
71.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column.	IN .	IN	71.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable column.			
93. 00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94.00
, 00	applicable column.			700
	If line 94 is "Y", enter the reduction percentage in the applicable column.	0. 00	0.00	95.00
96. 00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	N	N	96.00
97. 00	applicable column.  If line 96 is "Y", enter the reduction percentage in the applicable column.	0. 00	0. 00	97.00
98. 00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post	γ	V. 00	98.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in			
	column 1 for title V, and in column 2 for title XIX.			
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.	Y	Υ	98. 01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation	Υ	Υ	98. 02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1			
98. 03	for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)	N	N	98. 03
70. 03	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	IN	IN	70.03
	for title V, and in column 2 for title XIX.			
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	N	N	98. 04
	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			
98. 05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on	Υ	Υ	98. 05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in			
00.07	column 2 for title XIX.	V	V	00.07
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in	Y	Υ	98. 06
	column 2 for title XIX.			
	Rural Providers			
	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106. 00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R	N		107.00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If			
	yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost			
108 00	reimbursed. If yes complete Wkst. D-2, Pt. II.	N		108. 00
100.00	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			100.00
	-			

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0030	Period: From 01/01, To 12/31,		Worksheet S Part I Date/Time P	
	Physi cal	Occupati ona			5/30/2018 9 Respi rator	): 1 <u>3 am</u>
	1. 00	2. 00	3. 00		4.00	
09.00 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.
				-	1. 00	
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worlapplicable.	"Y" for yes or	"N" for no.	If yes,	s	N	110.
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this construction yes or "N" for no in column 1. If the response to continuous in the properties of the FCHIP demo in which this CAH is participated in the participation of the FCHIP demo in which this CAH is participated in the properties of the properties of the participated in the	ost reporting olumn 1 is Y, rticipating ir	period? Ente enter the column 2.	1.00 N		2.00	111.
				1.00	2.00 3.0	00
Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2.  3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	. If column 2 nt for long te	is "E", ente erm care (inc	r in column Iudes	N	0	 115.
16.00 s this facility classified as a referral center? Enter "Y" 17.00 s this facility legally-required to carry malpractice insurno.	,		r "N" for	N Y		116. 117.
18.00 s the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1	if the polic	y is	1		118
		Premi ums	Losse	es .	Insurance	
		1.00	2.00	)	3. 00	
18.01 List amounts of malpractice premiums and paid losses:			1	0		0118
18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched			1. 00 N	)	2. 00	118
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen	n column 1, ¨"\ ualifies for t	/" for yes or the Outpatien			N	119 120
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	Y			121
22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.						122
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N			125
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, er	nter the certi		e			126
in column 1 and termination date, if applicable, in column 2 7.00 f this is a Medicare certified heart transplant center, end	ter the certif	ication date				127
in column 1 and termination date, if applicable, in column 2 28.00 oll f this is a Medicare certified liver transplant center, end	ter the certif	cation date				128
in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified lung transplant center, ento		cation date	i n			129
column 1 and termination date if applicable in column 2	enter the cer	ti fi cati on				130
·	Lumn 2					131
30.00 f this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col 31.00 f this is a Medicare certified intestinal transplant center	r, enter the d	certi fi cati on				
30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col 1f this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col	r, enter the d lumn 2. ter the certif					132
30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col 31.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col 32.00 If this is a Medicare certified islet transplant center, en	r, enter the c lumn 2. ter the certif 2. ter the certif 2.	ication date				132 133 134

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COM	HENRY COUNTY ME	Provider CCN	N: 15-0030	From O		u of Form CMS Worksheet S- Part I Date/Time Pr	-2
						5/30/2018 9:	13 am
					1. 00	2.00	
40.00 Are there any related organization chapter 10? Enter "Y" for yes of are claimed, enter in column 2	or "N" for no in column 1. I	f yes, and home	office co		Y		140. 0
1.00		00	1 0115)		3. 00	L	
If this facility is part of a o			ıgh 143 tl	he name ar	nd address	of the home	
office and enter the home office 41.00 Name:		ractor number.	Contro	actor's Nu	ımbor.		141 0
41.00 Name: 42.00 Street:	Contractor's Name: PO Box:		Contra	actor S Nu	illiber:		141. 0 142. 0
43. 00 Ci ty:	State:		Zip Co	ode:			143.0
•	·						
44.00	and the second of the Wardenberg	- 12				1.00	144.0
44.00 Are provider based physicians'	costs included in worksheet	. Ar				Y	144. 0
					1. 00	2.00	
45.00  f costs for renal services are inpatient services only? Enter no, does the dialysis facility period? Enter "Y" for yes or '46.00  Has the cost allocation method	"Y" for yes or "N" for no i include Medicare utilizatio 'N" for no in column 2.	n column 1. If c on for this cost	olumn 1 i reportino		N		145. 00 146. 00
Enter "Y" for yes or "N" for no yes, enter the approval date (r	o in column 1. (See CMS Pub. nm/dd/yyyy) in column 2.	15-2, chapter 4	0, §4020)	) If		1.00	
47.00 Was there a change in the stati						N	147. 0 148. 0
48.00 Was there a change in the order 49.00 Was there a change to the simpl				for no		N N	149. 0
47. 00 was there a change to the simple	Trica cost friaring metrica:	Part A	Part		itle V	Title XIX	147.0
		1. 00	2. 00		3. 00	4. 00	
Does this facility contain a proor charges? Enter "Y" for yes							
55. 00 Hospi tal	or it for no for each compe	N N	N	D. (Зее s	N N	N N	155. 0
56. 00 Subprovi der – TPF		N	N		N	N	156. C
57.00 Subprovi der - IRF		N	N		N	N	157.0
58. OO SUBPROVI DER 59. OO SNF		N	N		N	N	158. C
60.00HOME HEALTH AGENCY		N N	N		N	N N	160.0
61. 00 CMHC			N		N	N	161. C
						1. 00	
Mul ti campus						1.00	
65.00 s this hospital part of a Mult Enter "Y" for yes or "N" for no		one or more campu	ses in di	fferent C	BSAs?	N	165.0
	Name	County	State	Zi p Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	00 166. 0
						1. 00	1
Health Information Technology 67.00 Is this provider a meaningful u	(HIT) incentive in the Ameri user under §1886(n)? Enter	can Recovery and	Reinves N" for no	tment Act		Y	167. 0
68.00 If this provider is a CAH (line reasonable cost incurred for the	ne HIT assets (see instructi	ons)					0168. 0
68.01  f this provider is a CAH and i exception under §413.70(a)(6)(i					dshi p		168.0
	ul user (line 167 is "Y") ar				enter the	9. 9	99169.0
69.00 If this provider is a meaningfu transition factor. (see instruc			_			_	
				Ве	gi nni ng 1. 00	Endi ng 2. 00	

Health Financial Systems	In Lie	u of Form CMS-	2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	ICATION DATA	Provi der CCN:		Period: From 01/01/2017	Worksheet S-2	2
					Date/Time Pre 5/30/2018 9:1	
				1. 00	2. 00	
171.00  f   line 167 is "Y", does this provider have section 1876 Medicare cost plans reported of "Y" for yes and "N" for no in column 1. If 1876 Medicare days in column 2. (see instru	N n	C	171.00			

	FINANCIAL SYSTEMS  FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	ORIAL HOSPITAL Provider C	CN: 15-0030	In Lie Period: From 01/01/2017 To 12/31/2017		2 epared:
				Y/N	Date 0.00	13 alli
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS	N for all NO re	esponses. Ent	er all dates in	the	
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in		i nstructi ons			1.00
			1. 00	<u>Date</u> 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in the Medicare lyes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N N	2.00	3.00	2.00
3. 00						3.00
				Туре	Date	
	Ciarrai al Data and Dananta		1.00	2. 00	3. 00	
4. 00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Ceraccountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date available.	Y	A		4.00	
5. 00	column 3. (see instructions) If no, see instructions.  On Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.					5. 00
	These on the fired financial Statements. If yes, Sabin the	ooner i i dei on.		Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities	16				
6. 00 7. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see in	•	ne provider i	s N N		6. 00 7. 00
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N		8.00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	ns.				9. 00
10.00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.			N		10.00
11. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I& KIN AN AP	provea 	N	Y/N	11.00
	Bad Debts				1. 00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	fyes, see in	structi ons.	N	14.00
15.00	Did total beds available change from the prior cost report	ng period? If	yes, see ins	tructi ons.	N	15.00
			t A		t B	
		Y/N 1. 00	2. 00	Y/N 3. 00	Date 4.00	
	PS&R Data	1.00	2.00	3.00	1.00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	Y	04/10/2018	Y	04/10/2018	16.00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00

19.00

but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0030 Period:		IS-2552-10
From 01/01/2017 To 12/31/2017	Date/Time F 5/30/2018	Prepared:
Description Y/N	Y/N	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R N	3. 00 N	20.00
Report data for Other? Describe the other adjustments:	IN IN	20.00
Y/N Date Y/N	Date	
1.00 2.00 3.00	4. 00	
21.00 Was the cost report prepared only using the provider's N N records? If yes, see instructions.		21.00
	1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)	1.00	
Capital Related Cost		
22.00 Have assets been relifed for Medicare purposes? If yes, see instructions	N	22. 00
23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost	N	23. 00
reporting period? If yes, see instructions.		
24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period?  If yes, see instructions	N	24.00
25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25. 00
26.00   Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see	N	26.00
instructions.		
27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit	N	27. 00
copy. Interest Expense		
28.00 Were new Loans, mortgage agreements or Letters of credit entered into during the cost reporting	Υ	28. 00
period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)	N	29. 00
treated as a funded depreciation account? If yes, see instructions		
30.00   Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see	N	31.00
i nstructi ons.		
Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual	l N	32.00
arrangements with suppliers of services? If yes, see instructions.		
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? I	f N	33. 00
no, see instructions. Provider-Based Physicians		
34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?	l N	34.00
If yes, see instructions.		
35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35. 00
Y/N	Date	
1.00	2. 00	
Home Office Costs	T	
36.00 Were home office costs claimed on the cost report?  N  N  N  N  N  N  N  N  N  N  N  N  N		36.00
37.00   If line 36 is yes, has a home office cost statement been prepared by the home office?   N   If yes, see instructions.		37. 00
38.00   If line 36 is yes , was the fiscal year end of the home office different from that of N		38. 00
the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes,		39.00
see instructions.		37.00
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Instructions.		40.00
This tructions.		
	00	
Cost Report Preparer Contact Information		
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,		41.00
respecti vel y.		
42.00 Enter the employer/company name of the cost report BLUE & CO., LLC		42.00
preparer.  43.00 Enter the telephone number and email address of the cost   317-713-7957   KCSMITH@BLUEAN	IDCO. COM	43.00
report preparer in columns 1 and 2, respectively.		121.23

Heal th	Financial Systems HENRY COUNT	/ MEN	MORIAL HOSPITAL	In Lie	In Lieu of Form CMS-2552-10				
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	Ξ	Provi der CCN: 15-0030	Peri od: From 01/01/2017	Worksheet S-2				
					Date/Time Pre 5/30/2018 9:1	pared: 3 am			
			3. 00						
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the title/position	1	SENI OR MANAGER			41.00			
	held by the cost report preparer in columns 1, 2, and	3,							
	respectively.								
42.00	Enter the employer/company name of the cost report					42.00			
	preparer.								
43.00	Enter the telephone number and email address of the co	st				43.00			
	report preparer in columns 1 and 2, respectively.								

| Period: | Worksheet S-3 | From 01/01/2017 | Part | To | 12/31/2017 | Date/Time Prepared: 
 Heal th Fi nancial
 Systems
 HENRY COUNTY
 MEMORIAL
 HOSPITAL

 HOSPITAL
 AND
 HOSPITAL HEALTH
 CARE
 COMPLEX
 STATISTICAL
 DATA
 Provider
 CC
 Provi der CCN: 15-0030

						То	12/31/2017	Date/Time P 5/30/2018 9		
								I/P Days /		
								0/P Visits	/	
								Trips		
	Component	Worksheet A Line Number	No	o. 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		38	13, 87	70	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 IPF Subprovider									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			38	13, 87	0	0. 00		0	7. 00
0.00	beds) (see instructions)	21 00		10	2 / 1	_	0.00		0	0.00
8. 00	INTENSIVE CARE UNIT	31. 00		10	3, 65	OU	0. 00		٥	8. 00 9. 00
9. 00 10. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT		ŀ							10.00
11.00	SURGICAL INTENSIVE CARE UNIT		ŀ							11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)		ŀ							12.00
13. 00	NURSERY	43.00	ŀ						o	13.00
14. 00	Total (see instructions)	43.00		48	17, 52	20	0. 00		ol	14.00
15. 00	CAH visits		ŀ	40	17, 52		0.00		0	15.00
16. 00	SUBPROVI DER - I PF								Ĭ	16.00
17. 00	SUBPROVI DER - I RF	41.00		0		0			o	17.00
18. 00	SUBPROVI DER	42.00		0		0			o	18. 00
19. 00	SKILLED NURSING FACILITY			_		-			Ĭ	19. 00
20.00	NURSING FACILITY								1	20.00
21.00	OTHER LONG TERM CARE									21. 00
22.00	HOME HEALTH AGENCY	101.00							0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)									23.00
24.00	HOSPI CE	116. 00		0		0				24.00
24. 10	HOSPICE (non-distinct part)	30.00								24. 10
25.00	CMHC - CMHC									25.00
26.00	NEW CASTLE FAMILY & INTERNAL MED	88. 00							0	26.00
26. 01	NCFIM- NORTHFIELD PARK	88. 01							0	26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00							0	26. 25
27.00	Total (sum of lines 14-26)			48						27.00
28. 00	Observation Bed Days								0	28. 00
29. 00	Ambul ance Trips									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	1	0				32.00
32. 01	Total ancillary labor & delivery room									32. 01
22 00	outpatient days (see instructions)									22 00
	LTCH non-covered days LTCH site neutral days and discharges									33. 00 33. 01
33. UI	Liton si të neutrar days and discharges		l		I		l		I	JJ. UI

 
 Heal th Fi nancial
 Systems
 HENRY COUNTY
 MEMORIAL
 HOSPITAL

 HOSPITAL
 AND
 HOSPITAL HEALTH
 CARE
 COMPLEX
 STATISTICAL
 DATA
 Provider
 CC
 Provi der CCN: 15-0030

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

				'	0 12/31/2017	5/30/2018 9: 1	
		I/P Davs	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	3, 056	97	6, 212			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)	0	1, 514				2.00
3. 00	HMO IPF Subprovider	0	0				3. 00
4. 00	HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6. 00	Hospi tal Adul ts & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	3, 056	97	6, 212			7. 00
	beds) (see instructions)	07.1	,				
8. 00	INTENSIVE CARE UNIT	974	6	1, 645			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)		2.4	700			12.00
13.00	NURSERY	4 000	34	720	0.00	270 05	13.00
14.00	Total (see instructions)	4, 030	137	8, 577	0. 00	378. 85	1
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - I PF	0	0	0	0.00	0.00	16.00
17. 00	SUBPROVIDER - IRF	U U	0	0	0.00		
18.00	SUBPROVI DER		U	0	0.00	0.00	•
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY						19.00
							20. 00 21. 00
21. 00 22. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY	4, 959	0	11, 233	0. 00	14. 21	•
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	4, 939	U	11, 233	0.00	14. 21	23.00
24. 00	HOSPICE	0	0	0	0.00	0.00	•
24. 00	1		0	0	0.00	0.00	24.00
25. 00	HOSPICE (non-distinct part) CMHC - CMHC	٩	U	U			25.00
26. 00	NEW CASTLE FAMILY & INTERNAL MED	6, 475	2, 306	17, 301	0.00	44.00	
26. 00	NCFIM- NORTHFIELD PARK	271	2, 306 132	942	0.00	l e	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	2/1	0	942	0.00		26. 25
27. 00	Total (sum of lines 14-26)	٩	U	U	0.00		27.00
28. 00	Observation Bed Days		31	924	0.00	444. 20	28.00
29. 00	Ambul ance Trips	0	٥١	924			29.00
30.00		٥		0			30.00
30.00	Employee discount days (see instruction) Employee discount days - LRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	28	70			32.00
32. 00	Total ancillary labor & delivery room	٥	20	70			32.00
J∠. U I	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	0					33.00
	LTCH site neutral days and discharges	ol ol					33.00
55. 51	12.5 5. to floatrai days and discharges	١			I	I	1 00.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0030

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

5/30/2018 9:13 am Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 12. 00 13.00 14. 00 11.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 1, 107 28 2, 356 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) 0 404 2.00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 Hospital Adults & Peds. Swing Bed SNF 5 00 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) INTENSIVE CARE UNIT 8.00 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 13.00 Total (see instructions) 2, 356 14.00 0.00 0 1, 107 28 14.00 CAH visits 15.00 15.00 16.00 SUBPROVIDER - IPF 16.00 17.00 SUBPROVIDER - IRF 0.00 0 0 17.00 18.00 SUBPROVI DER 0.00 18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00 21.00 OTHER LONG TERM CARE 21.00 HOME HEALTH AGENCY 22.00 0.00 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24.00 HOSPI CE 0.00 24.00 24. 10 HOSPICE (non-distinct part) 24.10 25.00 CMHC - CMHC 25.00 NEW CASTLE FAMILY & INTERNAL MED 0.00 26.00 26,00 26.01 NCFIM- NORTHFIELD PARK 0.00 26.01 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 0.00 26.25 Total (sum of lines 14-26) 27 00 0 00 27 00 Observation Bed Days 28.00 28.00 29.00 Ambul ance Trips 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) LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

| Period: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0030

						o 12/31/2017	Date/Time Pre 5/30/2018 9:1	
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	3 alli
		Number	Reported	i on of Sal ari es	Sal ari es (col . 2 ± col .	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col. 4	col . 5)	
		1. 00	2. 00	A-6) 3.00	4.00	F 00	. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5. 00	6. 00	
	SALARI ES	1						
1. 00	Total salaries (see instructions)	200. 00	38, 611, 321	-132, 338	38, 478, 983	1, 235, 751. 00	31. 14	1.00
2.00	Non-physician anesthetist Part		0	О	O	0. 00	0. 00	2. 00
3. 00	A Non-physician anesthetist Part		0	0		0. 00	0. 00	3. 00
	В		O					
4. 00	Physician-Part A - Administrative		0	0	O	0. 00	0. 00	4. 00
4. 01	Physicians - Part A - Teaching		0	0	C	0. 00	0. 00	4. 01
5. 00	Physician and Non Physician-Part B		0	0	C	0. 00	0. 00	5. 00
6. 00	Non-physician-Part B for		3, 369, 237	О	3, 369, 237	103, 289. 00	32. 62	6. 00
	hospital-based RHC and FQHC services							
7. 00	Interns & residents (in an	21. 00	0	О	О	0.00	0. 00	7. 00
7. 01	approved program)		0			0.00	0.00	7 01
7.01	Contracted interns and residents (in an approved		U			0.00	0. 00	7. 01
0.00	programs)		0			0.00	0.00	0.00
8. 00	Home office and/or related organization personnel		0	0	C	0.00	0. 00	8. 00
9.00	SNF	44. 00	0 704 000	0	0 040 044	0.00	0.00	
10. 00	Excluded area salaries (see instructions)		9, 794, 269	155, 642	9, 949, 911	260, 528. 00	38. 19	10.00
	OTHER WAGES & RELATED COSTS			_				
11. 00	Contract Labor: Direct Patient Care		910, 158	0	910, 158	20, 532. 00	44. 33	11. 00
12.00	Contract Labor: Top Level		0	О	О	0. 00	0. 00	12. 00
	management and other management and administrative							
	servi ces							
13. 00	Contract Labor: Physician-Part A - Administrative		235, 004	0	235, 004	1, 951. 00	120. 45	13. 00
14.00	Home office and/or related		0	О	C	0. 00	0. 00	14.00
	orgainzation salaries and wage-related costs							
14. 01	Home office salaries		0	О	o			14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		14. 02 15. 00
13.00	- Administrative		O			0.00	0.00	13.00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	C	0. 00	0. 00	16. 00
	WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		9, 622, 246	0	9, 622, 246			17. 00
18. 00	Wage-related costs (other)		0	О	C			18. 00
19. 00	(see instructions) Excluded areas		1, 543, 296	0	1, 543, 296			19. 00
20. 00	Non-physician anesthetist Part		1, 343, 270	Ö	1, 343, 270			20.00
21. 00	A Non-physician anesthetist Part		0	_				21. 00
	В		0					
22. 00	Physician Part A - Administrative		0	0	C			22. 00
22. 01	Physician Part A - Teaching		0	0	C			22. 01
23.00	Physician Part B		0 895, 830	0	005 000			23.00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		875, 830 0	0	895, 830 0			24. 00 25. 00
25 50	approved program)		_					25 50
25. 50	Home office wage-related (core)		0					25. 50
25. 51	Relatéd organization		0	0	O C			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0	0	d			25. 52
	- Administrative -							
25. 53	wage-related (core) Home office & Contract		0	0	d			25. 53
	Physicians Part A - Teaching -							
	wage-related (core)			I	I			l

Health Financial Systems

HENRY COUNTY MEMORIAL HOSPITAL

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0030

Period:
From 01/01/2017
To 12/31/2017

Wighther Prepared:
5/30/2018 9: 13 am

Wkst. A Line
Number

Number

Reported

Number

Reported

Reporte

							3/30/2010 9. 1	3 aiii
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
OVERHEAD COSTS - DIRECT SALARIES								l
26.00	Employee Benefits Department	4.00	234, 274	0	234, 274	8, 095. 00	28. 94	26.00
27.00	Administrative & General	5. 00	5, 365, 896	67, 000	5, 432, 896	161, 490. 00	33. 64	27.00
28.00	Administrative & General under		249, 941	0	249, 941	1, 196. 00	208. 98	28. 00
	contract (see inst.)							1
29.00	Maintenance & Repairs	6. 00	0	0	0	0. 00	0.00	29. 00
30.00	Operation of Plant	7. 00	1, 092, 807	0	1, 092, 807	41, 863. 00	26. 10	30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0. 00	0. 00	31.00
32.00	Housekeepi ng	9. 00	512, 643	-16, 813	495, 830	43, 694. 00	11. 35	32.00
33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33.00
	(see instructions)							1
34.00	Dietary	10.00	730, 366	-517, 828	212, 538	13, 236. 00	16. 06	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							l
36.00	Cafeteri a	11. 00	0	301, 860	301, 860	18, 828. 00	16. 03	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0. 00	0.00	37.00
38.00	Nursing Administration	13.00	1, 677, 682	0	1, 677, 682	40, 034. 00	41. 91	38.00
39.00	Central Services and Supply	14. 00	440, 114	0	440, 114	16, 349. 00	26. 92	39.00
40.00	Pharmacy	15. 00	0	0	0	0. 00	0. 00	40.00
41.00	Medical Records & Medical	16. 00	700, 065	0	700, 065	33, 242. 00	21. 06	41.00
	Records Library							l
42.00	Social Service	17. 00	0	0	0	0. 00	0. 00	42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0. 00	43.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0030 Peri od: Worksheet S-3 From 01/01/2017 To 12/31/2017 Part III Date/Time Prepared: 5/30/2018 9:13 am Worksheet A Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Line Number Reported ion of Sal ari es Related to (col.2 ± col. Sal ari es Salaries in 3) (from col. 4 Worksheet A-6) 1. 00 2.00 3.00 4.00 5.00 6.00 PART III - HOSPITAL WAGE INDEX SUMMARY Net salaries (see 1.00 35, 492, 025 -132, 338 35, 359, 687 1, 133, 658. 00 31. 19 1.00 instructions) 2.00 Excluded area salaries (see 9, 794, 269 155, 642 9, 949, 911 260, 528. 00 38. 19 2.00 instructions) 3.00 Subtotal salaries (line 1 25, 697, 756 -287, 980 25, 409, 776 873, 130. 00 29. 10 3.00 minus line 2) 22, 483. 00 4.00 1, 145, 162 50. 93 4.00 Subtotal other wages & related 1, 145, 162 costs (see inst.) 5.00 Subtotal wage-related costs 9, 622, 246 9, 622, 246 0.00 37.87 5.00 (see inst.) 36, 177, 184 6.00 Total (sum of lines 3 thru 5) -287, 980 895, 613. 00 40. 39 6.00 36, 465, 164 Total overhead cost (see 10, 838, 007

11, 003, 788

-165, 781

378, 027. 00

28. 67

7.00

7.00

instructions)

HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0030	Peri od:	Worksheet S-3
		From 01/01/2017	Part IV
		To 12/31/2017	Date/Time Prepared:
			5/30/2018 9:13 am

Amount Reported   1.00
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST  1.00 401K Employer Contributions 2.00 Tax Shel tered Annuity (TSA) Employer Contribution 3.00 Nonqualified Defined Benefit Plan Cost (see instructions)  1.00  1.00  1.00  0.00  0.00  0.00  0.00  0.00
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST  1.00 401K Employer Contributions 1,760,658 1.00 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 0 2.00 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00
Part A - Core List RETIREMENT COST  1.00 401K Employer Contributions 1,760,658 1.00 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 0 2.00 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00
RETIREMENT COST  1. 00
1.00 401K Employer Contributions 1,760,658 1.00 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 0 2.00 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00
2.00 Tax Sheltered Annuity (TSA) Employer Contribution 0 2.00 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00
4.00 Qualified Defined Benefit Plan Cost (see instructions) 0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)
5.00 401K/TSA Plan Administration fees 0 5.00
6.00 Legal/Accounting/Management Fees-Pension Plan 0 6.00
7.00 Employee Managed Care Program Administration Fees 0 7.00
HEALTH AND INSURANCE COST
8.00   Health Insurance (Purchased or Self Funded) 6,398,640 8.00
8.01   Health Insurance (Self Funded without a Third Party Administrator) 0   8.01
8.02   Health Insurance (Self Funded with a Third Party Administrator) 0   8.02
8.03   Health Insurance (Purchased) 0   8.03
9.00 Prescription Drug Plan 0 9.00
10.00   Dental, Hearing and Vision Plan   245,353   10.00
11.00 Life Insurance (If employee is owner or beneficiary) 187,722 11.00
12.00   Accident Insurance (If employee is owner or beneficiary) 0   12.00
13.00 Disability Insurance (If employee is owner or beneficiary) 522,967 13.00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00
15.00 'Workers' Compensation Insurance 321,170   15.00
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.
Non cumulative portion)
TAXES
17.00 FICA-Employers Portion Only 2,582,004 17.00
18.00   Medicare Taxes - Employers Portion Only 0   18.00
19. 00 Unempl oyment I nsurance 2, 858   19. 00
20.00 State or Federal Unemployment Taxes 0 20.00
OTHER
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00
instructions))
22.00 Day Care Cost and Allowances 0 22.00
23.00   Tuition Reimbursement 40,000   23.00
24.00         Total Wage Related cost (Sum of lines 1 -23)         12,061,372         24.00
Part B - Other than Core Related Cost
25. 00 OTHER WAGE RELATED COSTS (SPECIFY)

Provider CCN: 15-0030

			10 12/31/2017	5/30/2018 9:1	
	Cost Center Description	<u> </u>	Contract	Benefit Cost	
			Labor		
			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		910, 158		1. 00
2.00	Hospi tal		910, 158	12, 061, 372	2.00
3.00	Subprovi der - IPF				3.00
4.00	Subprovi der - IRF		0	0	4.00
5. 00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6. 00
7. 00	Swing Beds - NF		0	0	7. 00
8. 00	Hospi tal -Based SNF				8. 00
9. 00	Hospi tal -Based NF				9. 00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	11.00
12.00					12.00
13. 00			0	0	13.00
14.00	· ·		0	0	14.00
14. 01	Hospital-Based Health Clinic RHC 1		0	0	14.01
15. 00	· ·		0	0	15. 00
16. 00	· ·				16.00
17.00				_	17.00
18. 00	Other		0	0	18. 00

Heal th	Financial Systems HE	ENRY COUNTY MEM	ORIAL HOSPITAL		In lie	u of Form CMS-2	2552-10
	EALTH AGENCY STATISTICAL DATA	LINICI COUNTI MEM	Provi der C	CN: 15-0030	Period: From 01/01/2017	Worksheet S-4	
			Component	CCN: 15-7430	To 12/31/2017	5/30/2018 9:1	pared: 3 am
					Home Health Agency I	PPS	
						00	
0. 00	County						0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5. 00	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	3.00	
1.00	Home Heal th Ai de Hours	0		I .	0 00 0.00		
2. 00	Unduplicated Census Count (see instructions)	0.00	281.00		ployees (Full Ti		2.00
		Enter the number		Staff	Contract	Total	
		your normal	work week				
		C	)	1.00	2. 00	3.00	
2 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES		0.00	J 2	20 20	0.00	2 00
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		0.00	0. (			1
5.00	Other Administrative Personnel			0.0		l e	1
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			0. (			1
8. 00	Physical Therapy Service			0.0			1
9.00	Physical Therapy Supervisor			0.0			1
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			0. (			1
12.00	Speech Pathology Service			0.0	0. 00	0.00	12.00
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. (			13. 00 14. 00
15. 00	Medical Social Service Supervisor			0.0			1
16. 00	Home Health Aide			0.0			16. 00
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0.0			17. 00 18. 00
10.00	HOME HEALTH AGENCY CBSA CODES			0.1	0.00	0.00	10.00
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost				2		19. 00
	reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			34620			20.00
	during this cost reporting period (line 20 contains the first code).						
20. 01				99915			20. 01
		Full Ep Without	With Outliers	  LUPA Episode	s PEP Only	Total (cols.	
		Outliers			Epi sodes	1-4)	
	PPS ACTIVITY DATA	1.00	2. 00	3.00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	1, 755	245	1	52 40		1
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	501, 814 1, 929	69, 583 42		28 11, 426 10 18		1
24. 00	Physical Therapy Visit Charges	564, 217	12, 306	1			1
25. 00	Occupational Therapy Visits	406	28	1	1 8	443	1
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	113, 891 16	7, 879 C	1	37 2, 296 0 0	124, 353 16	1
28. 00	Speech Pathology Visit Charges	4, 614	C	•	0 0	4, 614	28. 00
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	0	C	1	0 0	0	29. 00 30. 00
31. 00	Home Heal th Aide Visits	318	82	2	1 8	409	1
32.00	Home Heal th Aide Visit Charges	43, 688	11, 274 397		1, 104		1
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4, 424	397	1	54 74	4, 959	33.00
34.00	Other Charges	0	101 043		0 0	0	
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1, 228, 224	101, 042	18, 28	33 20, 100	1, 367, 649	35. 00
36. 00	Total Number of Episodes (standard/non	286		:	25 6	317	36.00
37. 00	outlier) Total Number of Outlier Episodes		11		1	12	37.00
	Total Non-Routine Medical Supply Charges	1, 153		•	45 1		38.00

OSPITAL-BASED RHC/FQHC STATISTICAL DATA	HENRY COUNTY MEM		CCN: 15-0030	Peri od:	eu of Form CMS- Worksheet S-8	
30, 1, 1, 2, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,			CCN: 15-8520	From 01/01/201 To 12/31/201	7 7 Date/Time Pre	epare
				RHC I	5/30/2018 9: 1 Cost	13 am
				1		
				1	1. 00	
Clinic Address and Identification  OO Street				2200 FOREST R	DIDGE DADKWAY	1.
.00  Street		C	ity	State	ZIP Code	1.
			. 00	2.00	3. 00	
00 City, State, ZIP Code, County		NEW CASTLE		1	N 47362	2.
					1.00	-
00 HOSPITAL-BASED FQHCs ONLY: Designation - E	Enter "R" for rura	al or "U" for	urban		1.00	3.
			_	nt Award	Date	
				1. 00	2. 00	
Source of Federal Funds  OO Community Health Center (Section 330(d), F	DUS Act)		T		T	4.
00 Migrant Health Center (Section 330(d), PHS						5.
00 Health Services for the Homeless (Section						6.
00 Appalachian Regional Commission						7.
00 Look-Alikes 00 OTHER (SPECIFY)						8. 9.
OU JUHIER (SPECITI)						7.
				1. 00	2. 00	
Does this facility operate as other than a yes or "N" for no in column 1. If yes, inc 2. (Enter in subscripts of line 11 the type hours.)	dicate number of d	other operatio	ons in column	N	C	10.
(1.1.5.1. C. )	Sund	day	N	londay	Tuesday	
	from	to	from	to	from	
Facility hours of operations (1)	1. 00	2. 00	3.00	4.00	5. 00	-
Facility hours of operations (1) .00 CLINIC	1.00	2. 00	07: 30	4. 00	5. 00	11.
	1.00	2.00		17: 00	07: 30	11.
. 00 CLINIC			07: 30	17: 00		
.00 CLINIC  1.00 Have you received an approval for an exception in the second state of the second se	otion to the produ ined in CMS Pub. 1 column 1. If yes,	uctivity stanc 100-04, chapte enter in colu	o7:30  dard? er 9, section umn 2 the	17: 00 1. 00 N	07: 30	12
2.00 CLINIC  2.00 Have you received an approval for an exception of the second	otion to the produ ined in CMS Pub. 1 column 1. If yes,	uctivity stanc 100-04, chapte enter in colu	lard? er 9, section mm 2 the ders and	17: 00 1. 00 N	07: 30 2. 00 CCN number	12.
2.00 CLINIC  2.00 Have you received an approval for an except is this a consolidated cost report as defined as the second second in the second second in the second	otion to the produ ined in CMS Pub. 1 column 1. If yes,	uctivity stanc 100-04, chapte enter in colu	lard? er 9, section umn 2 the ders and Provi	17: 00 1. 00 N	07: 30 2. 00	12 13
.00 CLINIC  .00 Have you received an approval for an except is this a consolidated cost report as defined as the second s	otion to the produ ned in CMS Pub. 1 column 1. If yes, rt. List the names	uctivity stanc 100-04, chapte enter in colu s of all provi	lard? er 9, section umn 2 the ders and Provi	17: 00 1. 00 N N ider name 1. 00	07: 30 2. 00 CCN number 2. 00	12 13
.00 CLINIC  .00 Have you received an approval for an except.00 Is this a consolidated cost report as defi 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report numbers below.	otion to the produ ined in CMS Pub. 1 column 1. If yes,	uctivity stanc 100-04, chapte enter in colu	lard? er 9, section umn 2 the ders and Provi	17:00 1.00 N N	07: 30 2. 00 CCN number	12 13
2.00 Have you received an approval for an exception of the second of the	potion to the production of th	uctivity stanc 100-04, chapte enter in colu s of all provi V	lard? er 9, section mm 2 the ders and  Provi	17:00 1.00 N N ider name 1.00	07: 30  2. 00  CCN number 2. 00  Total Visits	12 13.
.00 CLINIC  .00 Have you received an approval for an exception of the second of the se	potion to the production of th	uctivity stanc 100-04, chapte enter in colu s of all provi V	lard? er 9, section mm 2 the ders and  Provi	17:00 1.00 N N ider name 1.00	07: 30  2. 00  CCN number 2. 00  Total Visits	12 13.
.00 CLINIC  .00 Have you received an approval for an exception of the second of the se	potion to the production of th	uctivity stanc 100-04, chapte enter in colu s of all provi V 2.00	lard? er 9, section mn 2 the ders and  Provi  XVIII 3.00	17:00 1.00 N N ider name 1.00	07: 30  2. 00  CCN number 2. 00  Total Visits	12 13.
.00 CLINIC  .00 Have you received an approval for an exception of the second of the se	potion to the production of th	uctivity stance 100-04, chapte enter in colus s of all provi  V 2.00	lard? er 9, section imn 2 the ders and  Provi  XVIII 3.00	17:00 1.00 N N ider name 1.00	07: 30  2. 00  CCN number 2. 00  Total Visits	12 13.
.00 CLINIC  .00 Have you received an approval for an exception of the second state of	otion to the production of the	uctivity stance 100-04, chapte enter in colus s of all provi  V 2.00	lard? er 9, section mn 2 the ders and  Provi  XVIII 3.00	17:00 1.00 N N ider name 1.00	07: 30  2. 00  CCN number 2. 00  Total Visits	12 13 13 14 15
2.00 Have you received an approval for an exception and the state of t	potion to the production of th	Uctivity stand 100-04, chapte enter in colu s of all provi  V 2.00  Column	lard? er 9, section imn 2 the ders and  Provi  XVIII 3.00	17:00  1.00  N N N  ider name 1.00  XIX 4.00	07: 30  2. 00  CCN number 2. 00  Total Visits 5. 00	12 13.
2.00 Have you received an approval for an except as defined and approval for no incompart and approval for a substantial ly all approval.  4.00 RHC/FQHC name, CCN number  4.00 RHC/FQHC name, CCN number  5.00 Have you provided all or substantially all approval for a substantial ly all approval. If yes, enter in columns 2, 3 and 4 the number of program visits performed and lintern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	potion to the production of th	Uctivity stance 100-04, chapte enter in colu s of all provi  V 2.00  Column	lard? er 9, section mn 2 the ders and  Provi  XVIII 3.00	17:00  1.00  N N N  ider name 1.00  XIX 4.00	07: 30  2. 00  CCN number 2. 00  Total Visits 5. 00	11.

Health Financial Systems HE	NRY COUNTY MEM	ORIAL HOSPITAL	=	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0030	Peri od:	Worksheet S-8	
				From 01/01/2017		
		Component	CCN: 15-8520	To 12/31/2017		
		·			5/30/2018 9:1	3 am
				RHC I	Cost	
	Frid	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 30	17: 00				11.00

		NRY COUNTY MEN	MORIAL HOSPITA			eu of Form CMS-	
105PL	FAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (	CCN: 15-0030	Period: From 01/01/201	Worksheet S-8	3
			Component	CCN: 15-8525	To 12/31/201	7 Date/Time Pre	
					DUO 11	5/30/2018 9: 1	13 am
					RHC I I	Cost	
					1	1.00	-
	Clinic Address and Identification					. 00	
. 00	Street				152 WI TTENBRA 500	KER AVE, SUITE	1.00
			C	i ty	State	ZIP Code	
				. 00	2.00	3. 00	
. 00	City, State, ZIP Code, County		NEW CASTLE		1	N 47362	2.00
	HOCDITAL BACED FOLIO, ONLY Declaration Folio	II DII C				1.00	2 00
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for		nt Award	Date 0	3.00
					1. 00	2.00	
	Source of Federal Funds				1.00	2.00	
. 00	Community Health Center (Section 330(d), PHS	Act)					4.00
. 00	Migrant Health Center (Section 329(d), PHS A	ct)					5.00
. 00	Health Services for the Homeless (Section 34	O(d), PHS Act)					6.00
. 00	Appal achi an Regional Commission						7.00
. 00	Look-Alikes						8.00
. 00	OTHER (SPECIFY)						9.00
					1. 00	2.00	
0. 00	Does this facility operate as other than a h	ospi tal -based	RHC or FOHC? F	nter "Y" for			10.00
0. 00	yes or "N" for no in column 1. If yes, indic	•					10.00
	2. (Enter in subscripts of line 11 the type o						
	hours.)						
			nday		londay	Tuesday	
		from	to	from	to	from	
	Eacility hours of operations (1)	1. 00	2.00	3.00	4. 00	5. 00	
1 00	Facility hours of operations (1)			07: 30	17: 00	08: 00	11.00
1.00	TO CHAIN O			07.00	17.00	00.00	11.00
					1. 00	2.00	
2. 00	Have you received an approval for an excepti	on to the prod	uctivity stand	lard?	N		12.00
3.00	Is this a consolidated cost report as define	d in CMS Pub.		er 9 section	N	C	
	120 02 Enter "V" for you or "N" for no in cal						13.00
	30.8? Enter "Y" for yes or "N" for no in col			umn 2 the			13.00
	number of providers included in this report.			umn 2 the			13.00
				umn 2 the ders and		CCN number	13.00
	number of providers included in this report.			umn 2 the ders and Provi	ider name	CCN number	13.00
4. 00	number of providers included in this report.			umn 2 the ders and Provi	ider name		
4. 00	number of providers included in this report. numbers below.			umn 2 the ders and Provi	ider name		
	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number	List the name	s of all provi	umn 2 the ders and Provi	ider name 1.00	2. 00	14.00
	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all	Y/N 1.00	s of all provi	umn 2 the ders and Provi	ider name 1.00	2.00 Total Visits	14.00
	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	Y/N 1.00	s of all provi	umn 2 the ders and Provi	ider name 1.00	2.00 Total Visits	14.00
	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	Y/N 1.00	s of all provi	umn 2 the ders and Provi	ider name 1.00	2.00 Total Visits	14.00
	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	Y/N 1.00	s of all provi	umn 2 the ders and Provi	ider name 1.00	2.00 Total Visits	14.00
	number of providers included in this report.  numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	Y/N 1.00	s of all provi	umn 2 the ders and Provi	ider name 1.00	2.00 Total Visits	14.00
	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	Y/N 1.00	s of all provi	umn 2 the ders and Provi	ider name 1.00	2.00 Total Visits	14.00
	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	Y/N 1.00	s of all provi	umn 2 the ders and Provi	ider name 1.00	2.00 Total Visits	14.00
	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Y/N 1.00	V 2.00	mn 2 the ders and  Provi  XVIII  3.00	ider name 1.00	2.00 Total Visits	14.00
5. 00	number of providers included in this report.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00	V 2.00	mn 2 the ders and  Provi  XVIII  3.00	ider name 1.00	2.00 Total Visits	14. 00
5. 00	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Y/N 1.00	V 2.00	mn 2 the ders and  Provi  XVIII  3.00  unity .00	XIX 4.00	2.00 Total Visits 5.00	14.00
4. 00 5. 00	number of providers included in this report.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00  Tuesday	V 2.00	mn 2 the ders and  Provi  XVIII  3.00  unity .00	XIX 4.00	Z.00  Total Visits 5.00	14.00
5. 00	number of providers included in this report.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00  Tuesday to	V 2.00  Co HENRY Wedr	mn 2 the ders and  Provi  XVIII  3.00  mesday  to	XIX 4.00  Thu	Z. 00  Total Visits 5. 00	13.00
5. 00	number of providers included in this report.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00  Tuesday	V 2.00	mn 2 the ders and  Provi  XVIII  3.00  unity .00	XIX 4.00	Z.00  Total Visits 5.00	14.00

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu						2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co		Peri od:	Worksheet S-8	
		Component (		From 01/01/2017 To 12/31/2017		narod:
		Component	JON. 13-0323	10 12/31/2017	5/30/2018 9: 1	
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00   CLI NI C	07: 30	17: 00				11.00

Heal th	Financial Systems	HE	ENRY COUNTY MEN	MORIAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
HOSPI 7	AL-BASED HOSPICE IDENTIFICATION	I DATA		Provi der C	CN: 15-0030	Peri od:	Worksheet S-9	
				Hospi ce CC	N: 15-1564	From 01/01/2017 To 12/31/2017		pared:
						Hospi ce I		
		Undupl i cated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
		4 00	0.00	Facility		5.00		
	DART I FURNILLIEUT DAVO FOR O	1. 00	2.00	3.00	4.00	5. 00	6. 00	
1 00	PART I - ENROLLMENT DAYS FOR CO	JST REPURTING	PERIODS BEGINN	T BEFORE OCT	UBER 1, 2015 T			1 00
1. 00 2. 00	Hospice Continuous Home Care Hospice Routine Home Care							1.00 2.00
3. 00	Hospice Inpatient Respite Care							3.00
4. 00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
3.00	Part II - CENSUS DATA FOR COST	REPORTING PER	LODS BEGLANLING	REFORE OCTORE	R 1 2015			3.00
6. 00	Number of patients receiving	KEI OKTITIO TEK	DEGITION NO	DEFORE GOTOBE	1, 2010			6.00
0.00	hospi ce care							0.00
7.00	Total number of unduplicated							7.00
	Continuous Care hours billable							
	to Medicare							
8.00	Average Length of Stay (line 5							8. 00
	/ line 6)							
9. 00	Unduplicated census count							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days repor		3 and 4.			
				Title XVIII	Title XIX	0ther	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2.00	3.00	4. 00	
40.00	PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERIODS BEGI	NNING ON OR AF	TER OCTOBER 1	•	_	
10.00	Hospice Continuous Home Care			4 007		0 0	1	
11.00				4, 897	1	0 315		11. 00 12. 00
12. 00 13. 00	Hospice Inpatient Respite Care Hospice General Inpatient Care			48	1	0 0 4		12.00
	Total Hospice Days			4, 969	1	0 319		14.00
14.00	PART IV - CONTRACTED STATISTICA	AL DATA FOR CO	ST REPORTING D					14.00
15. 00	Hospice Inpatient Respite Care	L DATA FOR CO.	JI KLI UKTING F	CKTODS BEGINNI		0 0		15.00
	Hospice General Inpatient Care					0 0		16.00
10.00	1ssp. ss serierar impatriont dare			1	1	51	1	1 .0.00

Heal th	Financial Systems HENRY COUNT	TY MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10				
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CO	CN: 15-0030	Peri od:	Worksheet S-1					
	From 01/01/2017					norod.				
				To 12/31/2017	Date/Time Pre 5/30/2018 9:1					
	Uncompensated and indigent care cost computation									
1.00	Cost to charge ratio (Worksheet C, Part I line 202 co	lumn 3 divided by li	ine 202 colum	n 8)	0. 349314	1.00				
	Medicaid (see instructions for each line)									
2.00	Net revenue from Medicaid				6, 442, 791	2.00				
3. 00 4. 00	Did you receive DSH or supplemental payments from Med If line 3 is yes, does line 2 include all DSH and/or		ts from Modis	ai dO	Y Y	3. 00 4. 00				
5. 00	If line 4 is no, then enter DSH and/or supplemental p	11 1 3		ai u :	0	5.00				
6. 00	Medical d charges	ayılıcırıs irolli wedi cai	ı u		27, 694, 756	6.00				
7. 00	Medicaid cost (line 1 times line 6)				9, 674, 166					
8.00	Difference between net revenue and costs for Medicaid	program (line 7 mir	nus sum of li	nes 2 and 5; if	3, 231, 375	8.00				
	< zero then enter zero)									
	Children's Health Insurance Program (CHIP) (see instr	uctions for each lir	ne)							
9.00	Net revenue from stand-alone CHIP				0					
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10. 00 11. 00				
12.00	Difference between net revenue and costs for stand-al	one CHIP (Line 11 mi	inus line 9·	if < zero then	0	12.00				
12.00	enter zero)	one onn (inne in iiii	inds into 7,	TI \ ZCI O THOI	O	12.00				
	Other state or local government indigent care program	(see instructions f	for each line	)						
13.00	Net revenue from state or local indigent care program	(Not included on li	ines 2, 5 or	9)	0	13.00				
14. 00	Charges for patients covered under state or local ind	igent care program (	(Not included	in lines 6 or	0	14.00				
45.00	[10]					45.00				
15. 00 16. 00	State or local indigent care program cost (line 1 tim Difference between net revenue and costs for state or		o program (Li	ao 15 minus lina	0	15. 00 16. 00				
10.00	13; if < zero then enter zero)	rocar murgem care	e program (11	ie io illinus iine	U	10.00				
	Grants, donations and total unreimbursed cost for Med	icaid, CHIP and stat	te/Local indi	gent care progra	ıms (see					
47.00	instructions for each line)	and the Confloration			0	47.00				
17. 00 18. 00	Private grants, donations, or endowment income restri Government grants, appropriations or transfers for su				0	17. 00 18. 00				
19. 00	Total unreimbursed cost for Medicaid , CHIP and state			s (sum of lines	3, 231, 375					
	8, 12 and 16)			•						
			Uni nsured	I nsured pati ents	Total (col. 1 + col. 2)					
			patients 1.00	2. 00	3.00					
	Uncompensated Care (see instructions for each line)		1.00	2.00	0.00					
20.00	Charity care charges and uninsured discounts for the	entire facility	997, 56	9 0	997, 569	20.00				
	(see instructions)									
21. 00	Cost of patients approved for charity care and uninsu	red discounts (see	348, 46	5 0	348, 465	21. 00				
22. 00	instructions) Payments received from patients for amounts previous	v written off as		o	0	22. 00				
22.00	charity care	y with their off do			G	22.00				
23.00	Cost of charity care (line 21 minus line 22)		348, 46	5 0	348, 465	23.00				
					1 00					
24 00	Doos the amount on line 20 column 2 include charges	1. 00 N	24. 00							
24.00	24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?									
25. 00	If line 24 is yes, enter the charges for patient days	0	25. 00							
26 00	Stay limit		2 711 402	26 00						
26. 00 27. 00	Total bad debt expense for the entire hospital comple Medicare reimbursable bad debts for the entire hospit				2, 711, 683 144, 621	26. 00 27. 00				
27. 00	Medicare allowable bad debts for the entire hospital				222, 495					
28. 00	Non-Medicare bad debt expense (see instructions)	p. o (500 1115t) ut	,		2, 489, 188					
29. 00	Cost of non-Medicare and non-reimbursable Medicare ba	d debt expense (see	instructions	)	947, 382					
	Cost of uncompensated care (line 23 column 3 plus lin	•			1, 295, 847					
31.00	Total unreimbursed and uncompensated care cost (line	19 plus line 30)			4, 527, 222	31.00				

Heal th	Financial Systems HE	NRY COUNTY MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC	F	eriod: rom 01/01/2017 o 12/31/2017	Worksheet A Date/Time Pre 5/30/2018 9:1	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		5, 050, 640	5, 050, 640			
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0	0	626, 577	626, 577	1
3. 00 4. 00	O0300 OTHER CAPITAL RELATED COSTS   O0400 EMPLOYEE BENEFITS DEPARTMENT	234, 274	8, 488, 913	8, 723, 187	0 132, 338	0 8, 855, 525	
5. 00	00500 ADMINISTRATIVE & GENERAL	5, 365, 896	9, 684, 814	15, 050, 710	· ·	15, 117, 710	1
7. 00	00700 OPERATION OF PLANT	1, 092, 807	1, 651, 437	2, 744, 244		2, 740, 349	
8.00	00800 LAUNDRY & LINEN SERVICE	0	363, 436	363, 436		363, 436	8.00
9.00	00900 HOUSEKEEPI NG	512, 643	298, 634	811, 277		784, 670	
10.00	01000 DI ETARY 01100 CAFETERI A	730, 366	611, 285 0	1, 341, 651		390, 423	1
11. 00 13. 00	01300 NURSI NG ADMI NI STRATI ON	0 1, 677, 682	370, 023	0 2, 047, 705	,	554, 504 2, 047, 705	
14. 00	01400 CENTRAL SERVICES & SUPPLY	440, 114	365, 061	805, 175		805, 175	1
15.00	01500 PHARMACY	0	3, 838, 985	3, 838, 985		3, 701, 650	
16.00	01600 MEDICAL RECORDS & LIBRARY	700, 065	255, 613	955, 678	0	955, 678	16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	0.407.044	E04 004	4 000 445	707 740	0.005.007	1 00 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	3, 497, 814 1, 038, 837	534, 301 174, 016	4, 032, 115 1, 212, 853		3, 325, 397 1, 211, 973	
41.00	04100 SUBPROVI DER - I RF	1,030,037	174, 010	1, 212, 033	0	0	1
42.00	04200 SUBPROVI DER	o	0	O	0	0	1
43.00	04300 NURSERY	0	0	0	583, 529	583, 529	43.00
F0 00	ANCILLARY SERVICE COST CENTERS	0.404.040	4 050 400		1 470 047	0.007.000	
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	2, 121, 068	1, 959, 109	4, 080, 177 0		2, 907, 830 123, 189	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 476, 539	801, 395	2, 277, 934		2, 022, 067	
57.00	05700 CT SCAN	147, 179	752, 867	900, 046		900, 046	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	92, 102	477, 679	569, 781	0	569, 781	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	O	0	0	
60.00	06000 LABORATORY	1, 748, 885	1, 945, 233	3, 694, 118	0	3, 694, 118	1
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0 380, 632	0 115, 724	496, 356	-1, 649	0 494, 707	
66.00	06600 PHYSI CAL THERAPY	1, 346, 716	1, 047, 688	2, 394, 404		2, 393, 932	1
67. 00	06700 OCCUPATI ONAL THERAPY	160, 606	11, 416	172, 022		172, 022	
68. 00	06800 SPEECH PATHOLOGY	58, 991	4, 305	63, 296		63, 296	
69.00	06900 ELECTROCARDI OLOGY	131, 065	122, 868			253, 933	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	4, 674, 129	4, 674, 129 0		1, 319, 615 4, 300, 382	1
73.00	07300 DRUGS CHARGED TO PATIENTS		0		4, 300, 362	4, 300, 362	1
76. 00	03950 CARDI AC REHAB	136, 830	17, 041	153, 871	0	153, 871	1
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 NEW CASTLE FAMILY & INTERNAL MED	2, 917, 432	1, 422, 190			4, 722, 693	
	08801 NCFIM- NORTHFIELD PARK	574, 004	387, 490 0			435, 852 0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09100 EMERGENCY	2, 234, 505	1, 011, 317	٩	١	3, 245, 822	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,201,000	1,011,017	0,210,022		0, 210, 022	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1, 071, 897	343, 361	1, 415, 258	0	1, 415, 258	101. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		٥			0	113. 00
	11400 UTI LI ZATI ON REVI EW-SNF	0	0		0		114.00
	11600 H0SPI CE	377, 156	321, 943	699, 099	0	699, 099	
118.00		30, 266, 105	47, 102, 913	77, 369, 018	-409, 233	76, 959, 785	118. 00
	NONREI MBURSABLE COST CENTERS						4
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1 5(0 200	0		190.00
	19200   PHYSI CI ANS' PRI VATE OFFI CES   07950   HOSPI TALI ST	905, 434 4, 813	662, 865 155, 226	1, 568, 299 160, 039	· ·	1, 542, 499 160, 039	
	07951 RENTAL	4, 013	155, 220	100,037	42, 669		194. 01
	07952 CMHS	0	0	O	0		194. 02
	07953 MCH	0	0	O	0		194. 03
	07954 WI C	o o	107 (00	107 (00	0		194.04
	07955 OTHER NONREIMBURSABLE COSTS 07956 RHC- FOREST RIDGE	1, 089, 137	127, 698	127, 698 1, 630, 374		127, 698 1, 772, 945	
	07957 PHI LLI PS HALL	1,007,137	541, 237 0	1,030,374	142, 3/1		194.00
	07958 OB DRS		Ö		l o		194. 08
1 / 1. 00	07959 THE WATERS	0	O	0	423, 331	423, 331	
194. 09			248, 786	807, 869	0	807, 869	
194. 09 194. 10	07960 CAMBRI DGE CI TY	559, 083		E/4 0:-	_	E/4 0/-	
194. 09 194. 10 194. 11	07961 WELL BEING	390, 394	171, 474	561, 868		561, 868	
194. 09 194. 10 194. 11 194. 12	07961 WELL BEING 07962 ACTIVATE HEALTH EMPLOYER CLINIC	390, 394 138, 635	171, 474 98, 095	236, 730	0	236, 730	194. 12
194. 09 194. 10 194. 11 194. 12 194. 13	07961 WELL BEING	390, 394	171, 474		0 -27, 000		194. 12 194. 13
194. 09 194. 10 194. 11 194. 12 194. 13 194. 14 194. 15	07961 WELL BEING 07962 ACTIVATE HEALTH EMPLOYER CLINIC 07963 NEW CASTLE PEDIATRICS	390, 394 138, 635 3, 176, 763	171, 474 98, 095 1, 195, 212	236, 730 4, 371, 975 1, 334, 347	0 -27, 000 0 -146, 538	236, 730 4, 344, 975	194. 12 194. 13 194. 14 194. 15

Health Financial Systems HENRY COUNTY MEMORIAL HO						RIAL HOSPITAL In Lieu of Form CMS-2552-1				2552-10	
RECLASSI FI CATI ON	AND ADJUSTMENTS OF	TRIAL BALANCE O	F EXPENSES		Provi der	CCN:	15-0030		riod: om 01/01/2017	Worksheet A	
								То	12/31/2017	Date/Time Pre 5/30/2018 9:1	
Cost	Center Description		Sal ari es		Other	Tot	al (col.	1 I	Recl assi fi cat	Recl assi fi ed	
						+	col. 2)		ions (See	Trial Balance	
									A-6)	(col. 3 +-	
										col. 4)	
			1. 00		2.00		3.00		4. 00	5. 00	
200 00 TOTA	L (SUM OF LINES 118	through 199)	38 611 3	321	51 951 9	91	90 563 3	12	0	90 563 312	200 00

Provi der CCN: 15-0030

Peri od: Worksheet A From 01/01/2017 Date/Time Prepared: 5/20/2018 9:13 am

			5/30/2018 9:1	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
		Allocation		
GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT	-75, 311	4, 932, 660		1.00
2. 00   00200 NEW CAP REL COSTS-MVBLE EQUIP	0	626, 577		2.00
3. 00 00300 OTHER CAPITAL RELATED COSTS	0	O		3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 576, 973	10, 432, 498		4. 00
5. 00   00500   ADMINISTRATIVE & GENERAL	-3, 135, 569	11, 982, 141		5.00
7. 00 00700 OPERATION OF PLANT	0	2, 740, 349		7.00
8. 00   00800 LAUNDRY & LINEN SERVICE	0	363, 436		8.00
9. 00   00900 HOUSEKEEPI NG 10. 00   01000 DI ETARY	0 -107, 172	784, 670 283, 251		9.00
11. 00   01100   CAFETERI A	-357, 293	197, 211		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	2, 047, 705		13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	805, 175		14. 00
15. 00 01500 PHARMACY	-757, 373	2, 944, 277		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-6, 265	949, 413		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS	-559	3, 324, 838		30.00
31. 00   03100   NTENSI VE CARE UNI T	0	1, 211, 973		31.00
41. 00   04100   SUBPROVI DER -   1 RF 42. 00   04200   SUBPROVI DER	0	0		41. 00 42. 00
43. 00   04300   NURSERY	0	583, 529		43.00
ANCI LLARY SERVICE COST CENTERS		000, 027		10.00
50. 00 05000 OPERATING ROOM	0	2, 907, 830		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	123, 189		52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	-15, 151	2, 006, 916		54.00
57. 00   05700   CT   SCAN	-518, 671	381, 375		57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	-324, 445	245, 336		58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY	-2, 997	2 401 121		59. 00 60. 00
60. 01   06000   LABORATORY	-2, <del>99</del> 7	3, 691, 121		60.00
65. 00 06500 RESPIRATORY THERAPY	-14, 811	479, 896		65.00
66. 00 06600 PHYSI CAL THERAPY	-803, 543	1, 590, 389		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	172, 022		67.00
68.00 06800 SPEECH PATHOLOGY	0	63, 296		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	253, 933		69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	1, 319, 615		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	4, 300, 382		72.00
73. 00   07300   DRUGS CHARGED TO PATI ENTS 76. 00   03950   CARDI AC REHAB	0	153, 871		73. 00 76. 00
OUTPATIENT SERVICE COST CENTERS	0	155, 671		70.00
88. 00 08800 NEW CASTLE FAMILY & INTERNAL MED	-553, 184	4, 169, 509		88. 00
88.01 08801 NCFIM- NORTHFIELD PARK	-245, 876	189, 976		88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	o		89. 00
91. 00   09100   EMERGENCY	-13, 881	3, 231, 941		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS	15 502	1 200 (/5		101 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	-15, 593	1, 399, 665		101.00
113. 00 11300 INTEREST EXPENSE	0	0		113.00
114. 00 11400 UTILIZATION REVIEW-SNF	0	o		114.00
116. 00 11600 HOSPI CE	-10, 366	688, 733		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-5, 381, 087	71, 578, 698		118. 00
NONREI MBURSABLE COST CENTERS				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1 542 400		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 HOSPI TALI ST	0	1, 542, 499		192.00 194.00
194. 01 07950  HUSPI TALTST 194. 01 07951  RENTAL	0	160, 039 42, 669		194.00
194. 02 07952 CMHS	0	42,009		194.01
194. 03 07953 MCH	0	0		194. 03
194. 04 07954 WI C	0	O		194. 04
194.05 07955 OTHER NONREIMBURSABLE COSTS	0	127, 698		194.05
194. 06 07956 RHC- FOREST RIDGE	0	1, 772, 945		194. 06
194. 07 07957 PHI LLI PS HALL	0	0		194. 07
194. 08 07958 OB DRS	0	0		194. 08
194. 09 07959 THE WATERS	0	423, 331		194.09
194. 10 07960  CAMBRI DGE CLTY 194. 11 07961  WELL BEING	0	807, 869 561, 868		194. 10 194. 11
194.11 07961 WELL BEING 194.12 07962 ACTIVATE HEALTH EMPLOYER CLINIC	0	236, 730		194. 11
194. 13 07963 NEW CASTLE PEDIATRICS	0	4, 344, 975		194. 12
194. 14 07964 HENRY COUNTY RADIOLOGY	0	1, 334, 347		194. 14
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY	0	2, 065, 932		194. 15
194.16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	182, 625		194. 16
200.00 TOTAL (SUM OF LINES 118 through 199)	-5, 381, 087	85, 182, 225		200.00

Heal th	Financial Systems	H	HENRY COUNTY MEMORIAL HOSPITAL				In Lieu of Form CMS-2552-10			
RECLASSI FI CATI ONS				Provi der 0	CCN: 15-0030	Peri od: From 01/01/2017	Worksheet A-	6		
						To 12/31/2017	Date/Time Pr 5/30/2018 9:			
		Increases								
	Cost Center	Li ne #	Sal ary	0ther						
	2. 00	3. 00	4. 00	5. 00						
	A - OB/NURSERY/L&D									
1.00	NURSERY	43. 00	504, 498	79, 031				1.00		
2 00	DELLIVEDY DOOM & LABOR DOOM	52 00	106 505	16 601				2 00		

Peri od: Worksheet A-6
From 01/01/2017
To 12/31/2017 Date/Time Prep

							To 12/31/2017	Date/Time Prepared: 5/30/2018 9:13 am
Cost Center			Decreases					3/30/2018 9. 13 alli
A - OBANDRSERY/LDD		Cost Center		Sal ary	Other	Wkst. A-7 Ref	.	
1.00								
2.00    0		A - OB/NURSERY/L&D	<u> </u>					
0	1.00	ADULTS & PEDIATRICS	30.00	611, 003	95, 715		0	1.00
B - CAFETER   A	2.00		0.00	0	0		o	2.00
1.00				611, 003	95, 715		7	
1.00		B - CAFETERIA					<u>'</u>	
C - WATERS EXCLUSIONS	1.00		10.00	301, 860	252, 644		0	1.00
C - WATERS EXCLUSIONS			T	301, 860	252, 644		7	
DIETARY		C - WATERS EXCLUSIONS					·	
D - DEPRECIATION POB	1.00	HOUSEKEEPI NG	9. 00	16, 813	9, 794		0	1.00
1.00   NEW CAP REL COSTS-BLDG & 1.00   0   42,669   9   1.00	2.00	DI ETARY	10.00	215, 968	180, 756		o	2.00
1.00   NEW CAP REL COSTS-BLDG &   1.00   0   42,669   9			T	232, 781	190, 550		7	
FLXT		D - DEPRECIATION POB					·	
C   C   C   C   C   C   C   C   C   C	1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	42, 669		9	1.00
E - EQUI PMENT RENTAL    Column		FIXT						
1.00   OPERATION OF PLANT   7.00   0   3,895   9   1.00   2.00   PHARMACY   15.00   0   137,335   0   2.00   4.00   OPERATING ROOM   50.00   0   226,479   0   4.00   5.00   RADI OLOGY-DI AGNOSTI C   54.00   0   255,867   0   6.00   7.00   PHYSI CAL THERAPY   66.00   0   4.72   0   0   7.00   PHYSI CAL THERAPY   66.00   0   4.72   0   7.00   PHYSI CAL THERAPY   66.00   0   4.72   0   7.00   PHYSI CAL SUPPLIES CHARGED TO   71.00   0   4.300,382   0   7.00   PHYSI CAL SUPPLIES CHARGED TO   71.00   0   4.300,382   0   7.00   PHYSI CAL SUPPLIES CHARGED TO   71.00   0   4.300,382   0   8.00   NEW CASTLE PEDI ATRICS   194.13   27,000   0   0   0   8.00   NEW CASTLE PEDI ATRICS   194.13   27,000   0   0   8.00   HENRY COUNTY ANESTHESI OLOGY   194.15   15,000   0   0   9.0   0   0   0   0   9.0   0   0   0   9.0   OPHYSI CIANS' PRI VATE OFFICES   192.00   25,000   0   0   9.0   OPHYSI CIANS' PRI VATE OFFICES   192.00   25,000   0   0   9.0   0   0   0   0   9.0   0   0   0   0   9.0   0   0   0			T		42, 669		7	
2. 00   PHARNACY		E - EQUI PMENT RENTAL						
3.00	1.00	OPERATION OF PLANT	7. 00	0	3, 895		9	1.00
4.00   OPERATI NG ROOM   50.00   0   226, 479   0   0   4.00     5.00   RADI OLOGY-DI AGNOSTI C   54.00   0   225, 867   0   0   6.00     7.00   PHYSI CAL THERAPY   65.00   0   472   0   0   7.00     F - IMPLANTABLE DEVICES	2.00	PHARMACY	15. 00	0	137, 335		0	2.00
5.00   RADI OLOGY-DI AGROSTIC   54.00   0   255, 867   0   0   6.00   6.00   RESPIRATORY THERAPY   65.00   0   1,649   0   0   7.00   0   7.00   0   4.72   0   7.00   0   7.00   0   626, 577	3.00	INTENSIVE CARE UNIT	31. 00	0	880		0	3.00
6. 00 RESPIRATORY THERAPY 65. 00 0 1,649 0 7. 00 PHYSI CAL THERAPY 66. 00 0 472 0 7. 00 0 626,577	4.00	OPERATING ROOM	50.00	0	226, 479		0	4.00
7. 00 PHYSICAL THERAPY 66. 00 0 472 0 7. 00	5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	255, 867		0	5. 00
Column	6.00	RESPI RATORY THERAPY	65. 00	0	1, 649		0	6. 00
Table   Tabl	7.00	PHYSI CAL THERAPY	66. 00	0	472		0	7. 00
1. 00   MEDI CAL SUPPLIES CHARGED TO   71. 00   0   4, 300, 382   0   1   0   0   0   0   0   0   0   0		0	T		626, 577			
PATI ENTS   0   4,300,382   1   - MEDI CAL DI RECTOR RECLASS		F - IMPLANTABLE DEVICES						
1. 00   NEW CASTLE PEDI ATRI CS   192. 00   25, 000   0   0   0   0   2. 00     3. 00   HENRY COUNTY ANESTHESI OLOGY   194. 15   15, 000   0   0   0     J - VERO/RI FF RECLASS   192. 00   800   0   0   0     1. 00   HENRY COUNTY ANESTHESI OLOGY   194. 15   131, 538   0   0   0   0     2. 00   HENRY COUNTY ANESTHESI OLOGY   194. 15   131, 538   0   0   0   0     2. 00   HENRY COUNTY ANESTHESI OLOGY   194. 15   131, 538   0   0   0   0     2. 00   DHYSI CI ANS' PRI VATE OFFI CES   192. 00   800   0   0   0     1. 00   NCFI M- NORTHFI ELD PARK   88. 01   450, 532   75, 110   0   0     2. 00   TOTALS   450, 532   75, 110   0   0     1. 00   DERATI NG ROOM   50. 00   0   945, 868   0   1. 00     1. 00   OPERATI NG ROOM   50. 00   0   945, 868   0   1. 00     1. 00   OPERATI NG ROOM   50. 00   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   OPERATI NG ROOM   50. 00   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   OPERATI NG ROOM   50. 00   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   0   1. 00     1. 00   TOTALS   0   945, 868   0   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   TOTALS   0   945, 868   0   1. 00     1. 00   0   0   0   0   0   0     1. 00   0   0   0   0   0	1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	4, 300, 382		0	1.00
1.00		PATI ENTS						
1. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 25, 000 0 0 0 2. 00 2. 00 NEW CASTLE PEDI ATRI CS 194. 13 27, 000 0 0 0 2. 00 3. 00 HENRY COUNTY ANESTHESI OLOGY 194. 15 15, 000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		S		0	4, 300, 382			
2. 00   NEW CASTLE PEDI ATRI CS   194. 13   27, 000   0   0   0   0     194. 15   15, 000   0   0   0     194. 15   15, 000   0   0   0     194. 15   15, 000   0   0     194. 15   131, 538   0   0   0     1. 00   HENRY COUNTY ANESTHESI OLOGY   194. 15   131, 538   0   0     2. 00   PHYSI CI ANS' PRI VATE OFFI CES   192. 00   800   0   0     10   TOTALS   132, 338   0     1. 00   NCFI M- NORTHFI ELD PARK   88. 01   450, 532   75, 110   0     2. 00   TOTALS   450, 532   75, 110     1. 00   L - MED SUPPLI ES RECLASS     1. 00   OPERATI NG ROOM   50. 00   945, 868   0								
3. 00 HENRY COUNTY ANESTHESI OLOGY 194. 15 15,000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00		192. 00	25, 000	0		0	1.00
1.00   HENRY COUNTY ANESTHESI OLOGY   194. 15   131, 538   0   0   0   0	2.00	NEW CASTLE PEDIATRICS	194. 13	27, 000	0		0	2.00
1.00   HENRY COUNTY ANESTHESI OLOGY   194.15   131,538   0   0   0   0   1.00	3.00	HENRY COUNTY ANESTHESI OLOGY	1 <u>94.</u> 15	1 <u>5, 0</u> 00	0		O	3.00
1. 00 HENRY COUNTY ANESTHESI OLOGY 194. 15 131, 538 0 0 0 2. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 800 0 0 2. 00 TOTALS 132, 338 0 TOTALS 132, 338 0 TOTALS 132, 338 0 TOTALS 132, 338 0 TOTALS 1. 00 NORTHFI ELD PARK 88. 01 450, 532 75, 110 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		67, 000	0			
2. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 800 0 0 0 2. 00 TOTALS 132, 338 0 1 132, 338 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								
TOTALS 132, 338 0	1.00		194. 15		0		0	1.00
K - RHC STAFF RECLASS	2.00		1 <u>92.</u> 00		0		<u>o</u>	2.00
1. 00				132, 338	0			
2. 00								
TOTALS 450, 532 75, 110  L - MED SUPPLIES RECLASS  1. 00 OPERATI NG ROOM 50. 00 945, 868 0 1. 00  TOTALS 0 945, 868 1 0		NCFIM- NORTHFIELD PARK			75, 110		0	
L - MED SUPPLIES RECLASS  1. 00 OPERATI NG ROOM	2.00		0. 00				0	2.00
1. 00 OPERATING ROOM 50. 00 945, 868 0 1. 00 TOTALS 0 945, 868				450, 532	75, 110			
TOTALS 0 945, 868								
	1.00		<u>50.</u> 00	0			0	1.00
500.00   Grand Total: Decreases   1, 795, 514   6, 529, 515   500.00				0				
	500.00	Grand Total: Decreases		1, 795, 514	6, 529, 515			500.00

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

7.00

8.00

9.00

7.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0030 Peri od: Worksheet A-7 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 9:13 am Acqui si ti ons Begi nni ng Purchases Disposals and Donati on Total Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 46, 000 Land 1.00 0 1, 807, 282 2.00 Land Improvements 521, 427 521, 427 260, 393 2.00 3.00 41, 824, 817 16, 012, 109 Buildings and Fixtures 16, 012, 109 3.00 17, 136, 021 0 4.00 Building Improvements 258, 814 16, 584 16, 584 4.00 Fi xed Equi pment 15, 793, 813 4, 236, 470 0 4, 236, 470 5.00 1, 246, 057 5.00 0 6.00 Movable Equipment 41, 466, 732 2, 364, 471 2, 364, 471 4, 905, 631 6.00 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 101, 197, 458 23, 151, 061 23, 151, 061 23, 548, 102 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 101, 197, 458 23, 151, 061 O 23, 151, 061 23, 548, 102 10.00 10.00 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 46,000 0 1.00 0 2.00 Land Improvements 2,068,316 2.00 40, 700, 905 3.00 Buildings and Fixtures 0 3.00 4.00 Building Improvements 275, 398 0 4.00 5.00 Fixed Equipment 18, 784, 226 0 5.00 0 6.00 Movable Equipment 38, 925, 572 6.00

100, 800, 417

100, 800, 417

0

0

0

0

Heal	h Financial Systems	ENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECO	NCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
					From 01/01/2017 Fo 12/31/2017	Date/Time Pre	
						5/30/2018 9: 1	3 am
			SU	IMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	4, 761, 974	0	288, 666	5 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	(	0	0	2.00
3.00	Total (sum of lines 1-2)	4, 761, 974	0	288, 666	6 0	0	3.00
		SUMMARY O	F CAPI TAL				
	Cost Center Description	Other	Total (1)				
	·	Capi tal -Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)	,				

Heal th	n Financial Systems HE	ENRY COUNTY MEM	NORLAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0030	Peri od:	Worksheet A-7	
						Date/Time Pre 5/30/2018 9:1	pared: 3 am
		COMF	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tali zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1, 00	2.00	col . 2) 3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	0.00	1. 00	0.00	
1.00	NEW CAP REL COSTS-BLDG & FIXT	42, 815, 221	0	42, 815, 22	0. 424752	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	57, 985, 196	0	57, 985, 19	6 0. 575248	0	2.00
3.00	Total (sum of lines 1-2)	100, 800, 417		100, 800, 41	7 1. 000000	0	3.00
		ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY C	OF CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	NEW CAP REL COSTS-BLDG & FIXT	ENTERS 0	1	ı	0 4, 719, 305	0	1.00
2. 00	NEW CAP REL COSTS-BEDG & TTAT	0	•		0 4, 714, 303		
3. 00	Total (sum of lines 1-2)	0			5, 345, 882	1	
0.00	Total (Sam St Times 1 2)	J	Sl	JMMARY OF CAPI			0.00
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)			
			instructions)			9 through 14)	
		11 00	12.00	13.00	instructions)	15. 00	
	DART III DECONCILIATION OF CARLTAL COSTS C	11. 00	12.00	13.00	14. 00	15.00	

213, 355

213, 355

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
NEW CAP REL COSTS-BLDG & FIXT
NEW CAP REL COSTS-MVBLE EQUIP

0 0 0

0 0 0

4, 932, 660 1. 00 626, 577 2. 00 5, 559, 237 3. 00

1. 00 2. 00

3.00 Total (sum of lines 1-2)

Provider CCN: 15-0030 Worksheet A-8 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/30/2018 9:13 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Cost Center Description Amount Wkst. A-7 (2) Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP Α -75, 311 NEW CAP REL COSTS-BLDG & 1.00 1.00 REL COSTS-BLDG & FIXT (chapter lfi xt 2.00 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter EQUI P 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0 0.00 4.00 discounts (chapter 8) Refunds and rebates of 5.00 0.00 5.00 expenses (chapter 8) 6 00 Rental of provider space by 0 00 6 00 suppliers (chapter 8) 7.00 Tel ephone services (pay -31, 115 ADMINISTRATIVE & GENERAL 5.00 7.00 Α stations excluded) (chapter 21) 8.00 Television and radio service 0 8.00 0.00 0 (chapter 21) Parking lot (chapter 21) 9.00 0.00 9.00 10.00 Provi der-based physi ci an A-8-2 -2, 289 10.00 adjustment Sale of scrap, waste, etc. 11.00 0.00 11.00 0 (chapter 23) 12.00 Related organization A-8-1 -2, 221, 682 12.00 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -357, 293 CAFETERI A 14 00 В 11 00 O 14 00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0 0.00 supplies to other than pati ents Sale of drugs to other than 17.00 17.00 0.00 pati ents 18.00 Sale of medical records and -6, 265 MEDI CAL RECORDS & LI BRARY 16.00 18.00 В abstracts 19.00 Nursing and allied health 19.00 0.00 0 0 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.00 therapy costs in excess of limitation (chapter 14) OUTILIZATION REVIEW-SNF 25.00 Utilization review -114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 1.00 26.00 COSTS-BLDG & FLXT
Depreciation - NEW CAP REL IFI XT ONEW CAP REL COSTS-MVBLE 27.00 27.00 2.00 COSTS-MVBLE EQUIP FOUL P 28.00 Non-physician Anesthetist 0 \*\*\* Cost Center Deleted \*\*\* 19.00 28.00 Physicians' assistant 29.00 29.00 0.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 30.00 30.00 67.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions)

Provider CCN: 15-0030 Peri od: Worksheet A-8 

				To	12/31/2017	Date/Time Pre	
				Expense Classification on	Worksheet A	5/30/2018 9:1	3 am
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
31. 00	Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00	3.00	31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
33. 00	Depreciation and Interest OTHER OP REV - HUMAN RESOURSEC	В	-190	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
00.00	- MIS	5	170	EMI ESTEE BENETITIS BETTICTMENT	1. 00	J	00.00
34. 00	OTHER OP REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	34.00
35. 00	OTHER OP REV - COPIES RECEIPTS	В		ADMINISTRATIVE & GENERAL	5. 00	0	35.00
36. 00 36. 01	OTHER OP REV - PHY REAPP FEES   DI ETARY-OTHER OP REV	B B		ADMINISTRATIVE & GENERAL DIETARY	5. 00 10. 00	0	36. 00 36. 01
36. 02	OTHER OP REV - DIETARY -	В		DIETARY	10.00	0	36. 01
	OUTSI DE SAL	_	,				
38. 00	OTHER OP REV - DI ETARY	В	-29, 441	DI ETARY	10. 00	0	38. 00
38. 01	TRANSFERS OTHER OP REV - PHARMACY	В	757 979	DHADMACV	15. 00	0	38. 01
38. 02	OTHER OP REV - PHARMACT			PHARMACY ADULTS & PEDIATRICS	30. 00	0	38. 02
30. 02	REC TES TIETT TROO	Ь	337	ADDETS & FEDIATRICS	30.00	J	30.02
40.00	CT SCAN-OTHER OP REV	В		CT SCAN	57. 00	0	40.00
40. 01	OTHER OP REV - LABORATORY-LAB	В	-749	LABORATORY	60. 00	0	40. 01
40. 02	DRUG S OTHER OP REV-LABORATORY	В	11	LABORATORY	60. 00	0	40. 02
40. 02	OTHER OF REV - ATH TRAINING -	В		PHYSI CAL THERAPY	66.00	0	
	HLTH P	_	2.,, 2		33.33		
41. 00	OTHER OP REV - ATH TRAINING -	В	-7, 057	PHYSI CAL THERAPY	66. 00	0	41.00
42.00	OUTSI D	В	21 542	DUVELCAL THEDADY	44.00	0	42.00
42. 00	OTHER OP REV - AQUATICS - HLTH PROG	В	-21, 502	PHYSI CAL THERAPY	66. 00	0	42. 00
43.00	OTHER OP REV - PHYSICAL THER -	В	-612	PHYSI CAL THERAPY	66. 00	0	43.00
	HLTH						
44. 00	OTHER OP REV - PHYSICAL THER -	В	-9, 566	PHYSI CAL THERAPY	66. 00	0	44. 00
44. 01	EE   OTHER OP REV - PHYSICAL THER -	В	-73 639	PHYSI CAL THERAPY	66. 00	0	44. 01
	FIT F	5	70,007		00.00	J	
44. 02	NC FAMILY INTERNAL	В	-215, 250	NEW CASTLE FAMILY & INTERNAL	88. 00	0	44. 02
4F 00	MEDICINE-OTHER OP	D	10 170	MED	00.00	0	4F 00
45. 00	NC FAMILY INTERNAL MEDICINE-OTHER OP	В	-12, 170	NEW CASTLE FAMILY & INTERNAL MED	88. 00	0	45. 00
45. 01	NC FAMILY INTERNAL	В	-741	NEW CASTLE FAMILY & INTERNAL	88. 00	0	45. 01
	MEDICINE-OTHER OP			MED			
	PUBLIC RELATIONS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
45. 03	PUBLIC RELATIONS PUBLIC RELATIONS	A		ADMINISTRATIVE & GENERAL RADIOLOGY-DIAGNOSTIC	5. 00	0	
45. 04 45. 05	PUBLIC RELATIONS	A A		NEW CASTLE FAMILY & INTERNAL	54. 00 88. 00	0	45. 04 45. 05
			·	MED THE TRUE TO A THIRD THE MED	00.00	J	10.00
45. 07	PUBLIC RELATIONS	Α		NCFIM- NORTHFIELD PARK	88. 01	0	45. 07
45. 09	PUBLIC RELATIONS	A		EMERGENCY	91. 00	0	45. 09
45. 10	PUBLIC RELATIONS	A		HOME HEALTH AGENCY	101.00	0	45. 10
45. 11 45. 16	PUBLIC RELATIONS AHA & IHA DUES	A A		HOSPICE ADMINISTRATIVE & GENERAL	116. 00 5. 00	0	45. 11 45. 16
45. 16	BENEFIT EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	45. 16 45. 17
45. 17	HAF EXPENSE	Ä		ADMINISTRATIVE & GENERAL	5. 00	0	45. 17
45. 19	OTHER ADJUSTMENTS (SPECIFY)	•	0		0. 00	0	45. 19
	(3)						
50. 00	TOTAL (sum of lines 1 thru 49)		-5, 381, 087				50.00
	(Transfer to Worksheet A, column 6, line 200.)						
(1) D-				o CMS Dub. 1E 1			

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Peri od: Worksheet A-8-1 From 01/01/2017 Pote //Fire Prens

12/31/2017 Date/Time Prepared: 5/30/2018 9:13 am Li ne No. Cost Center Expense Items Amount of Allowable Cost Included in Wks. A, column 3. 00 5. 00 1.00 2.00 4 00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 54. 00 RADI OLOGY-DI AGNOSTI C 5. 489 18, 964 1.00 2.00 57. 00 CT SCAN 175, 658 694, 280 2.00 58. 00 MAGNETIC RESONANCE I MAGING ( 3.00 125, 555 450,000 3.00 3.01 66. 00 PHYSI CAL THERAPY 797, 641 191, 230 3.01 5. 00 ADMINISTRATIVE & GENERAL 161, 459 4.00 4.00 65. 00 RESPIRATORY THERAPY 4.01 25,700 40, 511 4.01 4.02 88.00 NEW CASTLE FAMILY & INTERNAL 139, 967 459, 273 4.02 4.03 88. 01 NCFIM- NORTHFIELD PARK 8, 298 251, 600 4.03 11, 727 21, 650 4.04 101.00 HOME HEALTH AGENCY 4.04 4.05 116. 00 HOSPI CE 11, 722 21, 650 4.05 5.00 TOTALS (sum of lines 1-4). 695, 346 2, 917, 028 5.00 Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.

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

	<u> </u>				
			Related Organization(s) and/	or Home Officel	
			3		1
					1
					1
					1
Symbol (1)	Name	Percentage of	Name	Percentage of	1
Symbol (1)	riamo		rame		1
		Ownershi p		Ownershi p	1
1. 00	2. 00	3, 00	4. 00	5. 00	
1.00	2. 00	3.00	4. 00	5.00	
B INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	OME OFFICE:			1
DI TITTETITEE TITTOTIONITE TO TREET	TEB GILGENITE ETT GIT (G) THIEF GIT THE	MIL OITTOLI			4

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	G	HENRY COUNTY HO	100. 00 H	IOSPI TAL FOUNDA	0. 00	6.00
7.00			0.00		0. 00	7.00
8. 00			0.00		0. 00	8. 00
9. 00			0.00		0. 00	9. 00
10.00			0.00		0. 00	10.00
100.00	G. Other (financial or	MI SC				100.00
	non-financial) specify:					

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

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

4.03

4 04

4.05

5.00

	Related Organization(s) and/or Home Office		
	Type of Business		
	6. 00		
-	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

i ci ilibai	Sement under the Aviii.	
	MI SC	6. 00
7.00		7.00
8.00		8. 00
9.00		9. 00
9. 00 10. 00 100. 00		10.00
100.00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

4.03

4.04

4.05

5.00

-243, 302

-2, 221, 682

-9.923

-9, 928

0

0

0

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0030

					-	Γο 12/31/2017	Date/Time Pre 5/30/2018 9:	
	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	60.00	LABORATORY	80, 004	0	80, 004	260, 300	621	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	0	0	0	8. 00
9. 00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			80, 004	0	80, 004		621	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of		Physician Cost	
		l denti fi er	Li mi t	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		LABORATORY	77, 715	1				
2. 00	0. 00		0	-		0	1	
3. 00	0. 00		0	1	_	0	0	
4. 00	0. 00		0	0	_	0	0	
5.00	0.00		0	0	0	0	0	
6. 00	0.00		0	0	0	0	0	
7. 00	0.00		0	0	0	0	0	
8. 00	0. 00		0	0	0	0	0	
9. 00	0. 00		0	0	0	0	0	
10.00	0. 00		0	0	0	0	0	
200.00			77, 715			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00	-	
1. 00		LABORATORY	15.00					1.00
2. 00	0.00	LABORATORT	0	77,719		2, 207	•	2.00
3. 00	0.00		0	0	_			3.00
4. 00	0.00		0	0	0			4.00
5. 00	0.00							5.00
6. 00	0.00		0	0	0			6.00
7. 00	0.00					0		7.00
8. 00	0.00		١	0	0			8.00
9. 00	0.00							9.00
10. 00	0.00							10.00
200.00	0.00			77, 715	2, 289	2, 289		200.00
200.00	1		1 0	1 ,,,,13	2, 209	2,209	I	1 200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0030

Cost Center Description  Net Expenses for Cost Allocation (from Wkst A col . 7)  O 1.00 2.00 4.00 4A    GENERAL SERVICE COST CENTERS
Fixt   Fixt
Fixt   Fixt
Allocation (from Wkst A col . 7)    GENERAL SERVICE COST CENTERS
CFrom Wkst A   Col . 7)   To   To   To   To   To   To   To   T
COI
CENERAL SERVICE COST CENTERS   1.00   00100   NEW CAP REL COSTS-BLDG & FIXT   4,932,660   4,932,660   2.00   00200   NEW CAP REL COSTS-MVBLE EQUIP   626,577   626,577   626,577   4.00   00400   EMPLOYEE BENEFITS DEPARTMENT   10,432,498   26,257   3,130   10,461,885   5.00   00500   ADMINISTRATIVE & GENERAL   11,982,141   620,465   73,965   1,486,179   14,162,750   7.00   00700   OPERATION OF PLANT   2,740,349   1,334,577   159,093   298,938   4,532,957   8.00   00800   LAUNDRY & LI NEN SERVICE   363,436   66,000   7,868   0   437,304   9.00   00900   HOUSEKEEPING   784,670   38,334   4,570   135,635   963,209   10.00   01000   DI ETARY   283,251   139,253   16,600   58,140   497,244   11.00   01100   CAFETERIA   197,211   38,045   4,535   82,574   322,365   13.00   01300   NURSING ADMINISTRATION   2,047,705   76,475   9,117   458,932   2,592,229   1
1. 00       00100 NEW CAP REL COSTS-BLDG & FIXT       4, 932, 660       4, 932, 660         2. 00       00200 NEW CAP REL COSTS-MVBLE EQUIP       626, 577       626, 577         4. 00       00400 EMPLOYEE BENEFITS DEPARTMENT       10, 432, 498       26, 257       3, 130       10, 461, 885         5. 00       00500 ADMINI STRATI VE & GENERAL       11, 982, 141       620, 465       73, 965       1, 486, 179       14, 162, 750         7. 00       00700 OPERATION OF PLANT       2, 740, 349       1, 334, 577       159, 093       298, 938       4, 532, 957         8. 00       00800 LAUNDRY & LINEN SERVI CE       363, 436       66, 000       7, 868       0       437, 304         9. 00       00900 HOUSEKEEPI NG       784, 670       38, 334       4, 570       135, 635       963, 209         10. 00       01000 DI ETARY       283, 251       139, 253       16, 600       58, 140       497, 244       1         11. 00       01100 CAFETERI A       197, 211       38, 045       4, 535       82, 574       322, 365       1         13. 00       01300 NURSI NG ADMINI STRATI ON       2, 047, 705       76, 475       9, 117       458, 932       2, 592, 229       1
2. 00     00200 NEW CAP REL COSTS-MVBLE EQUIP     626, 577       4. 00     00400 EMPLOYEE BENEFITS DEPARTMENT     10, 432, 498     26, 257     3, 130     10, 461, 885       5. 00     00500 ADMI NI STRATI VE & GENERAL     11, 982, 141     620, 465     73, 965     1, 486, 179     14, 162, 750       7. 00     00700 OPERATI ON OF PLANT     2, 740, 349     1, 334, 577     159, 093     298, 938     4, 532, 957       8. 00     00800 LAUNDRY & LI NEN SERVI CE     363, 436     66, 000     7, 868     0     437, 304       9. 00     00900 HOUSEKEEPI NG     784, 670     38, 334     4, 570     135, 635     963, 209       10. 00     01000 DI ETARY     283, 251     139, 253     16, 600     58, 140     497, 244       11. 00     01100 CAFETERI A     197, 211     38, 045     4, 535     82, 574     322, 365     1       13. 00     01300 NURSI NG ADMI NI STRATI ON     2, 047, 705     76, 475     9, 117     458, 932     2, 592, 229     1
4. 00     00400     EMPLOYEE BENEFITS DEPARTMENT     10, 432, 498     26, 257     3, 130     10, 461, 885       5. 00     00500     ADMINISTRATIVE & GENERAL     11, 982, 141     620, 465     73, 965     1, 486, 179     14, 162, 750       7. 00     00700     OPERATION OF PLANT     2, 740, 349     1, 334, 577     159, 093     298, 938     4, 532, 957       8. 00     00800     LAUNDRY & LI NEN SERVI CE     363, 436     66, 000     7, 868     0     437, 304       9. 00     00900     HOUSEKEEPI NG     784, 670     38, 334     4, 570     135, 635     963, 209       10. 00     01000     DI ETARY     283, 251     139, 253     16, 600     58, 140     497, 244     1       11. 00     01100     CAFETERI A     197, 211     38, 045     4, 535     82, 574     322, 365     1       13. 00     01300     NURSI NG ADMINISTRATION     2, 047, 705     76, 475     9, 117     458, 932     2, 592, 229     1
5. 00         00500         ADMI NI STRATI VE & GENERAL         11, 982, 141         620, 465         73, 965         1, 486, 179         14, 162, 750           7. 00         00700         OPERATI ON OF PLANT         2, 740, 349         1, 334, 577         159, 093         298, 938         4, 532, 957           8. 00         00800         LAUNDRY & LI NEN SERVI CE         363, 436         66, 000         7, 868         0         437, 304           9. 00         00900         HOUSEKEEPI NG         784, 670         38, 334         4, 570         135, 635         963, 209           10. 00         01000         DI ETARY         283, 251         139, 253         16, 600         58, 140         497, 244         1           11. 00         01300         NURSI NG ADMI NI STRATI ON         2, 047, 705         76, 475         9, 117         458, 932         2, 592, 229         1
7. 00   00700   OPERATI ON OF PLANT   2,740,349   1,334,577   159,093   298,938   4,532,957   8. 00   00800   LAUNDRY & LI NEN SERVI CE   363,436   66,000   7,868   0   437,304   9. 00   00900   HOUSEKEEPI NG   784,670   38,334   4,570   135,635   963,209   10. 00   01000   DI ETARY   283,251   139,253   16,600   58,140   497,244   1 1. 00   01100   CAFETERI A   197,211   38,045   4,535   82,574   322,365   1 13. 00   01300   NURSI NG ADMI NI STRATI ON   2,047,705   76,475   9,117   458,932   2,592,229   1
9. 00   00900   HOUSEKEEPI NG   784, 670   38, 334   4, 570   135, 635   963, 209   10. 00   01000   DI ETARY   283, 251   139, 253   16, 600   58, 140   497, 244   1 11. 00   01100   CAFETERI A   197, 211   38, 045   4, 535   82, 574   322, 365   1 13. 00   01300   NURSI NG ADMI NI STRATI ON   2, 047, 705   76, 475   9, 117   458, 932   2, 592, 229   1
10. 00     01000     DI ETARY     283, 251     139, 253     16, 600     58, 140     497, 244     1       11. 00     01100     CAFETERI A     197, 211     38, 045     4, 535     82, 574     322, 365     1       13. 00     01300     NURSI NG ADMI NI STRATI ON     2, 047, 705     76, 475     9, 117     458, 932     2, 592, 229     1
11. 00   01100   CAFETERI A   197, 211   38, 045   4, 535   82, 574   322, 365   1   13. 00   01300   NURSI NG ADMI NI STRATI ON   2, 047, 705   76, 475   9, 117   458, 932   2, 592, 229   1
13. 00   01300   NURSI NG ADMI NI STRATI ON   2, 047, 705   76, 475   9, 117   458, 932   2, 592, 229   1
15. 00   01500   PHARMACY   2, 944, 277   30, 135   3, 592   0 2, 978, 004   1
16. 00 01600 MEDICAL RECORDS & LIBRARY 949, 413 56, 758 6, 766 191, 503 1, 204, 440 1
INPATIENT ROUTINE SERVICE COST CENTERS
30. 00 03000 ADULTS & PEDI ATRI CS 3, 324, 838 570, 845 68, 050 789, 690 4, 753, 423 3 31. 00 03100 I NTENSI VE CARE UNI T 1, 211, 973 223, 812 26, 680 284, 175 1, 746, 640 3
31. 00   03100   I NTENSI VE CARE UNI T   1, 211, 973   223, 812   26, 680   284, 175   1, 746, 640   3   41. 00   04100   SUBPROVI DER -   I RF   0   0   0   0   0   0
42. 00   04200  SUBPROVI DER
43. 00   04300  NURSERY   583, 529   59, 189   7, 056   138, 006   787, 780   4
ANCILLARY SERVICE COST CENTERS
50. 00   05000   OPERATI NG ROOM   2, 907, 830   316, 223   37, 697   580, 220   3, 841, 970   5
52. 00   05200   DELI VERY ROOM & LABOR ROOM   123, 189   30, 077   3, 585   29, 135   185, 986   5
54. 00   05400   RADI 0LOGY-DI AGNOSTI C   2, 006, 916   218, 429   26, 039   403, 909   2, 655, 293   57. 00   05700   CT SCAN   381, 375   8, 450   1, 007   40, 261   431, 093   5
57. 00   05700   CT SCAN   381, 375   8, 450   1, 007   40, 261   431, 093   5 58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)   245, 336   10, 321   1, 230   25, 195   282, 082   5
59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   59.
60. 00   06000   LABORATORY   3, 691, 121   159, 375   18, 999   478, 409   4, 347, 904   6
60. 01   06001   BLOOD LABORATORY   0   0   0   0   6
65. 00   06500   RESPI RATORY THERAPY   479, 896   33, 492   3, 993   104, 122   621, 503   6
66. 00   06600   PHYSI CAL THERAPY   1,590,389   22,013   2,624   368,396   1,983,422   6
67. 00   06700   0CCUPATI ONAL THERAPY   172, 022   2, 045   244   43, 934   218, 245   68. 00   06800   SPEECH PATHOLOGY   63, 296   3, 723   444   16, 137   83, 600   6
69. 00   06900  ELECTROCARDI OLOGY   253, 933   0   0   35, 853   289, 786   6
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,319,615 0 0 1,319,615 7
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 4,300,382 0 0 0 4,300,382 7
73.00   07300   DRUGS CHARGED TO PATIENTS   0 0 0 0 0 0 7
76. 00 03950 CARDI AC REHAB 153, 871 13, 717 1, 635 37, 430 206, 653 7
OUTPATIENT SERVICE COST CENTERS           88.00         08800 NEW CASTLE FAMILY & INTERNAL MED         4, 169, 509         0         0         887, 882         5, 057, 391         8
88. 01   08801   NCFIM- NORTHFIELD PARK   189, 976   0   0   33, 776   223, 752   8
89. 00   08900  FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0
91. 00   09100   EMERGENCY   3, 231, 941   203, 883   24, 305   611, 251   4, 071, 380   9
92.00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)   0   9
OTHER REIMBURSABLE COST CENTERS
101. 00 10100 HOME HEALTH AGENCY 1, 399, 665 0 0 293, 218 1, 692, 883 10 SPECIAL PURPOSE COST CENTERS
113. 00 11300 I NTEREST EXPENSE 11
114. 00   11400   UTI LI ZATI ON REVI EW-SNF
116. 00 11600 H0SPI CE 688, 733 0 0 103, 171 791, 904 11
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   71,578,698   4,439,892   529,275   8,136,465   68,663,208   11
NONREI MBURSABLE COST CENTERS   190. 00   19, 466   19   19, 466   19   19, 466   19   19, 466   19   19   19   19   19   19   19
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 542, 499 0 0 240, 625 1, 783, 124 19
194. 00 07950 HOSPI TALIST 160, 039 0 0 1, 317 161, 356 19
194. 01 07951 RENTAL 42, 669 0 40, 880 0 83, 549 19
194. 02 07952 CMHS   0 0 0 0 0 19
194. 03 07953 MCH 0 0 0 19
194. 04 07954 WI C 0 0 0 0 19
194. 05 07955 OTHER NONREI MBURSABLE COSTS 127, 698 0 0 127, 698 19 194. 06 07956 RHC- FOREST RIDGE 1, 772, 945 0 0 331, 362 2, 104, 307 19
194. 07 07957 PHI LLI PS HALL 0 0 0 0 0 0 0 19
194. 08 07958 OB DRS 0 0 0 0 179
194. 09 07959 THE WATERS 423, 331 473, 302 56, 422 63, 677 1, 016, 732 19
194. 10 07960 CAMBRI DGE CI TY 807, 869 0 0 152, 938 960, 807 19
194. 11 07961 WELL BEING 561, 868 0 0 106, 793 668, 661 19
194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC 236, 730 0 0 37, 924 274, 654 19
194. 13 07963 NEW CASTLE PEDIATRICS 4, 344, 975 0 0 861, 621 5, 206, 596 19 194. 14 07964 HENRY COUNTY RADIOLOGY 1, 334, 347 0 0 41, 857 1, 376, 204 19

Health Financial Systems	HENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		Period: From 01/01/2017	Worksheet B Part I	
				To 12/31/2017	Date/Time Pre 5/30/2018 9:1	
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1. 00	2. 00	4. 00	4A	
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY	2, 065, 932	0		0 457, 006	2, 522, 938	194. 15
194.16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY	182, 625	0		0 30, 300	212, 925	194. 16
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers		0		0	0	201. 00
202.00   TOTAL (sum lines 118 through 201)	85, 182, 225	4, 932, 660	626, 57	7 10, 461, 885	85, 182, 225	202. 00

Provider CCN: 15-0030

			1	0 12/31/201/	Date/lime Pre 5/30/2018 9:1	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
GENERAL SERVICE COST CENTERS	5. 00	7. 00	8. 00	9. 00	10.00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	14, 162, 750					5. 00
7. 00   00700   OPERATION OF PLANT	903, 967	5, 436, 924				7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	87, 208	145, 611				8.00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000 DI ETARY	192, 084	84, 574			020 517	9.00
10. 00  01000  DI ETARY 11. 00  01100  CAFETERI A	99, 161 64, 286	307, 225 83, 936	7, 637 0	27, 250 13, 860	938, 517 0	10.00
13. 00 01300 NURSING ADMINISTRATION	516, 945	168, 723	0	18, 558	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	215, 378	304, 459		4, 698	0	14.00
15. 00 01500 PHARMACY	593, 877	66, 485	0	10, 101	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	240, 191	125, 223	0	3, 759	0	16.00
INPATIENT ROUTINE SERVICE COST CENTE						
30. 00   03000   ADULTS & PEDI ATRI CS	947, 932	1, 259, 415	135, 150		742, 022	30.00
31. 00   03100   INTENSIVE CARE UNIT 41. 00   04100   SUBPROVI DER - I RF	348, 317	493, 782	30, 496	22, 552	196, 495	1
41. 00   04100   SUBPROVI DER - I RF 42. 00   04200   SUBPROVI DER	0	0	0	0	0	41. 00 42. 00
43. 00   04300   NURSERY	157, 100	130, 586	11, 163	4, 463	0	43.00
ANCI LLARY SERVI CE COST CENTERS	1077.00	100,000	117.00	1, 100		10.00
50.00 05000 OPERATING ROOM	766, 169	697, 663	120, 484	100, 308	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	37, 090	66, 357	2, 357		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	529, 521	481, 907	48, 764	34, 532	0	54.00
57. 00 05700 CT SCAN	85, 969	18, 643		0	0	57.00
58.00 O5800 MAGNETI C RESONANCE I MAGI NG (MRI 59.00 O5900 CARDI AC CATHETERI ZATI ON	56, 253	22, 772 0	0	0	0	58. 00 59. 00
60. 00   06000   LABORATORY	867, 063	351, 619	l ~	75, 173	0	60.00
60. 01   06001   BLOOD   LABORATORY	007,003	331, 019	047	73, 173	0	60.00
65. 00 06500 RESPIRATORY THERAPY	123, 941	73, 891	Ö	29, 834	0	65.00
66. 00 06600 PHYSI CAL THERAPY	395, 536	48, 565	13, 499	129, 673	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	43, 523	4, 512	1, 259	12, 920	0	67.00
68. 00   06800   SPEECH PATHOLOGY	16, 672	8, 215	1	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	57, 789	0	0	9, 866	0	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT		0	0	0	0	71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENT 73.00   07300   DRUGS CHARGED TO PATIENTS	857, 586 0	0	0	0	0	72. 00 73. 00
76. 00 03950 CARDI AC REHAB	41, 211	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS	11,211			<u> </u>		70.00
88.00 08800 NEW CASTLE FAMILY & INTERNAL ME	D 1, 008, 550	0	0	0	0	88. 00
88.01 08801 NCFIM- NORTHFIELD PARK	44, 621	0	0	0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENT		0	0	0	0	89.00
91. 00   09100   EMERGENCY	811, 919	449, 814	120, 043	90, 912	0	91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	PART)					92.00
101.00 10100 HOME HEALTH AGENCY	337, 596	0	0	41, 345	0	101.00
SPECIAL PURPOSE COST CENTERS	337, 370			41, 545	0	1101.00
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
116. 00 11600 HOSPI CE	157, 922	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 throu	igh 117)   10, 868, 536	5, 393, 977	520, 135	967, 847	938, 517	118. 00
NONREIMBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CAN	TTTN 2 002	42.047		4 E70	0	100 00
192. 00 19000 GIFT, FLOWER, COFFEE SHOP & CAP	ITEEN 3, 882 355, 592	42, 947	333			190. 00 192. 00
194. 00 07950 HOSPI TALI ST	32, 178	0	0	0		194.00
194. 01 07951 RENTAL	16, 661	0	Ö	276, 964		194. 01
194. 02 07952 CMHS	o	0	0	0		194. 02
194. 03 07953 MCH	0	0	0	0		194. 03
194. 04 07954 WI C	0	0	0	0		194. 04
194. 05 07955 OTHER NONREI MBURSABLE COSTS	25, 466	0	14, 190			194.05
194. 06 07956 RHC- FOREST RIDGE	419, 643	0	4, 166			194. 06 194. 07
194.07 07957 PHILLIPS HALL 194.08 07958 0B DRS		0	5, 442 8, 992	· ·		194.07
194. 09 07959 THE WATERS	202, 758	0	116, 865			194.00
194. 10 07960 CAMBRI DGE CI TY	191, 605	0	0	0		194. 10
194. 11 07961 WELL BEING	133, 345	0	0	0		194. 11
194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC		0	0	0		194. 12
194. 13 07963 NEW CASTLE PEDIATRICS	1, 038, 279	0	0	0		194. 13
194. 14 07964 HENRY COUNTY RADI OLOGY	274, 444	0	0	0		194. 14
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY	503, 127	0	0	0		194. 15
194. 16 07966 NEW CASTLE IMMEDICATE CARE & FA	MI LY 42, 462	0	0	0	0	194. 16
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0	^	0	n	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 20	-	5, 436, 924	670, 123	1, 268, 303		
	, , , , , , , , , , , , , , , , , , , ,	.,,	1 2.0, .20	.,,		

Provider CCN: 15-0030

			10	12/31/2017	Date/lime Pre   5/30/2018 9:1	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O N	SERVI CES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						1 1 00
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT 2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
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 & LI NEN SERVI CE						8.00
9. 00   00900 HOUSEKEEPI NG 10. 00   01000 DI ETARY						9. 00 10. 00
11. 00   01100   CAFETERI A	484, 447					11.00
13. 00 01300 NURSING ADMINISTRATION	32, 756	3, 329, 211				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	13, 792	0	1, 618, 346			14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDICAL RECORDS & LIBRARY	0 27, 584	0	3, 765 3, 883	3, 652, 232 0	1 405 000	15. 00 16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	27, 304	U	ა, იია	U	1, 605, 080	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	79, 307	1, 078, 478	47, 497	0	164, 104	30.00
31.00 03100 INTENSIVE CARE UNIT	24, 136	328, 232	14, 021	0	70, 067	31.00
41. 00   04100   SUBPROVI DER -   I RF	0	0	0	0	0	41.00
42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY	12, 068	164, 116	0	0	0 47, 479	42. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	12, 000	101, 110	o <sub>l</sub>	<u> </u>	17, 177	10.00
50. 00 05000 OPERATING ROOM	63, 788	867, 470	85, 008	0	,	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 724	23, 445	0	0	107 202	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 57. 00   05700   CT   SCAN	39, 652 3, 448	0	32, 358 9, 925	0	197, 293 70, 528	54. 00 57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 448	Ö	4, 038	Ö	21, 665	1
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00   06000   LABORATORY	58, 616	0	179, 654	0	260, 906	60.00
60. 01   06001   BLOOD LABORATORY 65. 00   06500   RESPI RATORY   THERAPY	0 10, 344	0	0 1, 954	0	0 19, 361	60. 01 65. 00
66. 00   06600 PHYSI CAL THERAPY	41, 376	0	9, 163	0	13, 829	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	3, 448	0	0	0	1, 383	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 724	0	_ 4	0	461	68. 00
69. 00   06900   ELECTROCARDIOLOGY 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 448 0	0	5, 555 269, 866	0	14, 751 36, 877	69. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	881, 319	0	64, 996	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	Ö	0	0	3, 652, 232	0	73.00
76. 00 03950 CARDI AC REHAB	5, 172	70, 335	984	0	1, 844	76. 00
OUTPATIENT SERVICE COST CENTERS  88. OO 08800 NEW CASTLE FAMILY & INTERNAL MED	٥	0	7 514	0	0	00 00
88.00   08800   NEW CASTLE FAMILY & INTERNAL MED 88.01   08801   NCFIM- NORTHFIELD PARK	0	0	7, 516 1, 643	0		88. 00 88. 01
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	Ö	0	0	Ö	89.00
91. 00 09100 EMERGENCY	58, 616	797, 135	50, 174	0	339, 270	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY	ol	0	5, 475	0	9 680	101.00
SPECIAL PURPOSE COST CENTERS	٥	J.	37 173		7, 000	
113. 00 11300   I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF 116.00 11600 HOSPICE	0	0	4, 544	0	4 014	114. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	484, 447	3, 329, 211	1, 618, 346	3, 652, 232		
NONREI MBURSABLE COST CENTERS	,	5, 52., 2	1, 0.0, 0.0	3, 332, 232	.,,	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192. 00 19200  PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950  HOSPI TALI ST	0	0	0	0		192. 00 194. 00
194. 01 07951 RENTAL	0	0	0	0		194.00
194. 02 07952 CMHS	Ō	0	0	0		194. 02
194. 03 07953 MCH	0	0	0	0		194. 03
194.04 07954  WI C 194.05 07955  OTHER NONREIMBURSABLE COSTS	0	0	0	0		194. 04 194. 05
194. 05 07955 OTHER NONKET MBORSABLE COSTS 194. 06 07956 RHC- FOREST RIDGE	0	0	0	0		194.05
194. 07 07957 PHI LLI PS HALL	o	Ö	0	Ö		194. 07
194. 08 07958 OB DRS	0	0	0	0		194. 08
194. 09 07959 THE WATERS	0	0	0	0		194. 09
194. 10 07960  CAMBRI DGE CLTY 194. 11 07961  WELL BEING	0	0	0	0		194. 10 194. 11
194. 11 07961 WELL BEING 194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0		194. 11
194. 13 07963 NEW CASTLE PEDIATRICS	o	o	O	0	0	194. 13
194. 14 07964 HENRY COUNTY RADI OLOGY	0	0	0	0		194. 14
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY 194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0		194. 15 194. 16
200.00 Cross Foot Adjustments		U	U	U		200.00
201.00 Negative Cost Centers	О	0	0	0	0	201.00
	·		<u> </u>			

Health Financial Systems	HENRY COUNTY MEM	ORIAL HOSPITAL	_	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre 5/30/2018 9:1	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	

						5/30/2018 9:1	3 am
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI O	SERVICES &		RECORDS &	
			N	SUPPLY		LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16. 00	
202.00	TOTAL (sum lines 118 through 201)	484, 447	3, 329, 211	1, 618, 346	3, 652, 232	1, 605, 080	202.00

| Peri od: | Worksheet B | From 01/01/2017 | Part | | To | 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0030

					To 12/31/2017 Date/Time Pr 5/30/2018 9:	
	Cost Center Description	Subtotal	Intern &	Total	070072010 7.	TO dill
			Residents Cost & Post			
			Stepdown			
		24. 00	Adjustments 25.00	26.00	_	
	GENERAL SERVICE COST CENTERS	24.00	23.00	20.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT					1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL					5. 00
7.00	00700 OPERATION OF PLANT					7. 00 8. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON					11. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS					16.00
30. 00	03000 ADULTS & PEDIATRICS	9, 545, 371	0	9, 545, 37	1	30.00
	1 1	3, 274, 738	0			31.00
41. 00 42. 00	04100   SUBPROVI DER	0	0	•	0	41. 00 42. 00
	04300 NURSERY	1, 314, 755	0	•	5	43.00
	ANCILLARY SERVICE COST CENTERS		_		-1	
50. 00 52. 00	05000 OPERATING ROOM	6, 806, 532 316, 959	0			50. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 019, 320	Ö			54.00
57.00	05700 CT SCAN	619, 606	0			57.00
58. 00 59. 00	05800   MAGNETIC RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	390, 258	0		0 0	58. 00 59. 00
60.00	06000 LABORATORY	6, 141, 782	Ö	•	2	60.00
60. 01	06001 BLOOD LABORATORY	0	0	•	0	60. 01
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	880, 828 2, 635, 063	0			65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	285, 290	Ö			67.00
68.00	06800 SPEECH PATHOLOGY	110, 676	0			68.00
69. 00 71. 00	06900  ELECTROCARDI OLOGY   07100  MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	381, 195 1, 889, 517	0			69. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	6, 104, 283	0	6, 104, 28	3	72.00
	07300 DRUGS CHARGED TO PATIENTS 03950 CARDI AC REHAB	3, 652, 232	0			73. 00 76. 00
76.00	OUTPATIENT SERVICE COST CENTERS	326, 199	0	326, 19	7	76.00
88. 00	08800 NEW CASTLE FAMILY & INTERNAL MED	6, 073, 457	0			88.00
88. 01 89. 00	08801   NCFIM- NORTHFIELD PARK   08900   FEDERALLY QUALIFIED HEALTH CENTER	270, 016	0		6 0	88. 01 89. 00
91.00	09100 EMERGENCY	6, 789, 263	0	1		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	2, 086, 979	0	2, 086, 97	ol .	101.00
101.00	SPECIAL PURPOSE COST CENTERS	2,000,777		2,000,77	7	
	11300   INTEREST EXPENSE   11400   UTILIZATION REVIEW-SNF					113.00
	11400 HOSPI CE	961, 284	О	961, 28	4	114. 00 116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	64, 875, 603				118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	72, 873	0	72, 87	3	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	2, 139, 049				192.00
	07950 HOSPI TALI ST	193, 534	0	193, 53	4	194. 00
	07951 RENTAL 07952 CMHS	377, 174	0		4 O	194. 01 194. 02
	07953 MCH	0	0		0	194. 02
	07954 WI C	0	0	•	0	194. 04
	07955 OTHER NONREIMBURSABLE COSTS 07956 RHC- FOREST RIDGE	167, 354 2, 528, 116	0			194. 05 194. 06
194. 07	07957 PHILLIPS HALL	22, 356	Ö	22, 35	6	194. 07
	07958 OB DRS	8, 992	0			194.08
	07959 THE WATERS 07960 CAMBRIDGE CITY	1, 336, 355 1, 152, 412	0			194. 09 194. 10
194. 11	07961 WELL BEING	802, 006	0	802, 00	6	194. 11
	07962 ACTIVATE HEALTH EMPLOYER CLINIC	329, 426	0			194. 12
	07963 NEW CASTLE PEDIATRICS 07964 HENRY COUNTY RADIOLOGY	6, 244, 875 1, 650, 648	0			194. 13 194. 14
194. 15	07965 HENRY COUNTY ANESTHESI OLOGY	3, 026, 065	0	3, 026, 06	5	194. 15
194. 16	07966 NEW CASTLE IMMEDICATE CARE & FAMILY	255, 387	0	255, 38	<u>/ </u>	194. 16

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	N: 15-0030	Peri od: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Prepared: 5/30/2018 9:13 am	
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	24. 00	25. 00	26.00			
200.00 Cross Foot Adjustments	0	0		0	200.00	
201.00 Negative Cost Centers	0	0		0	201.00	
202.00   TOTAL (sum lines 118 through 201)	85, 182, 225	0	85, 182, 22	25	202. 00	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Part II | Par Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0030

			Io	12/31/2017	Date/lime Pre   5/30/2018 9:1	
		CAPITAL REL	ATED COSTS		10,00,20.0 7. 1	<u> </u>
Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FLXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1. 00	2.00	2A	4. 00	
GENERAL SERVICE COST CENTERS						
1. 00	0 0 0 0 0 0 0 0	26, 257 620, 465 1, 334, 577 66, 000 38, 334 139, 253 38, 045 76, 475 137, 999 30, 135 56, 758		29, 387 694, 430 1, 493, 670 73, 868 42, 904 155, 853 42, 580 85, 592 154, 450 33, 727 63, 524	29, 387 4, 188 839 0 381 163 232 1, 288 338 0 538	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0 0	570, 845 223, 812 0 0 59, 189	68, 050 26, 680 0 0 7, 056	638, 895 250, 492 0 0 66, 245	2, 217 798 0 0 387	30. 00 31. 00 41. 00 42. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS  50. 00   05000   OPERATI NG ROOM  52. 00   05200   DELI VERY ROOM & LABOR ROOM  54. 00   05400   RADI OLOGY-DI AGNOSTI C  57. 00   05700   CT SCAN  58. 00   05800   MAGNETI C RESONANCE   MAGI NG (MRI)  59. 00   05900   CARDI AC CATHETERI ZATI ON  60. 00   06000   LABORATORY	0 0 0 0 0	316, 223 30, 077 218, 429 8, 450 10, 321 0	37, 697 3, 585 26, 039 1, 007 1, 230 0	353, 920 33, 662 244, 468 9, 457 11, 551 0	1, 629 82 1, 134 113 71 0	50. 00 52. 00 54. 00 57. 00 58. 00 59. 00
60. 01   06001   BLOOD LABORATORY 65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY 67. 00   06700   0CCUPATI ONAL   THERAPY 68. 00   06800   SPEECH   PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	0 0 0 0 0 0 0 0	159, 375 0 33, 492 22, 013 2, 045 3, 723 0	18, 999 0 3, 993 2, 624 244 444 0	178, 374 0 37, 485 24, 637 2, 289 4, 167 0	1, 343 0 292 1, 034 123 45 101	60. 00 60. 01 65. 00 66. 00 67. 00 68. 00 69. 00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00   07200   IMPL. DEV. CHARGED TO PATIENT 73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 00   03950   CARDIAC REHAB	0 0 0 0	0 0 0 13, 717	0 0 0 1, 635	0 0 0 15, 352	0 0 0 105	71.00 72.00 73.00 76.00
88. 00   08800   NEW CASTLE FAMILY & INTERNAL MED   88. 01   08801   NCFIM- NORTHFIELD PARK   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   91. 00   09100   EMERGENCY   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 0	0 0 0 203, 883	0 0 0 0 24, 305	0 0 0 0 228, 188 0	2, 493 95 0 1, 716	88. 00 88. 01 89. 00 91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY	O	0	0	ol	823	101. 00
SPECIAL PURPOSE COST CENTERS  113.00 11300 INTEREST EXPENSE  114.00 11400 UTILIZATION REVIEW-SNF  116.00 11600 HOSPICE  118.00 SUBTOTALS (SUM OF LINES 1 through 117)  NONREIMBURSABLE COST CENTERS	0	0 4, 439, 892	0 529, 275	0 4, 969, 167	290 22, 858	113. 00 114. 00 116. 00 118. 00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950 HOSPI TALI ST 194. 01 07951 RENTAL 194. 02 07952 CMHS 194. 03 07953 MCH 194. 04 07954 WI C 194. 05 07955 OTHER NONREI MBURSABLE COSTS 194. 06 07956 RHC- FOREST RI DGE	0 0 0 0 0 0 0	19, 466 0 0 0 0 0 0 0	0 0 0 40, 880 0 0 0 0	19, 466 0 0 40, 880 0 0 0 0	676 4 0 0 0 0 0 930	190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06
194. 07 07957 PHILLIPS HALL 194. 08 07958 OB DRS 194. 09 07959 THE WATERS 194. 10 07960 CAMBRI DGE CITY 194. 11 07961 WELL BEING 194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC 194. 13 07963 NEW CASTLE PEDIATRICS 194. 14 07964 HENRY COUNTY RADIOLOGY 194. 15 07965 HENRY COUNTY ANESTHESIOLOGY	0 0 0 0 0 0 0	0 0 473, 302 0 0 0 0 0	0 0 56, 422 0 0 0 0 0	0 0 529, 724 0 0 0 0 0 0	0 179 429 300 106 2, 419 118	194. 07 194. 08 194. 09 194. 10 194. 11 194. 12 194. 13 194. 14 194. 15

Health Financial Systems	HENRY COUNTY MEM	IORI AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B	
				From 01/01/2017 To 12/31/2017	Part II   Date/Time Pre	epared:
					5/30/2018 9:1	3 am
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Di rectl y	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	Assigned New	FLXT	EQUI P		BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2.00	2A	4. 00	
194.16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	0		0 0	85	194. 16
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	4, 932, 660	626, 57	5, 559, 237	29, 387	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0030

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Part II | Par

			1	0 12/31/2017	Date/lime Pre   5/30/2018 9:1	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
GENERAL SERVICE COST CENTERS	5. 00	7. 00	8. 00	9. 00	10. 00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL	698, 618	1 500 100				5.00
7. 00   00700   0PERATI ON OF PLANT 8. 00   00800   LAUNDRY & LINEN SERVICE	44, 591 4, 302	1, 539, 100	1			7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG	9, 475	41, 220 23, 942				9.00
10. 00 01000 DI ETARY	4, 891	86, 970		1, 757	250, 995	10.00
11. 00   01100   CAFETERI A	3, 171	23, 761	0	894	0	11.00
13.00 01300 NURSING ADMINISTRATION	25, 500	47, 763	0	1, 196	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	10, 624	86, 187	0	303	0	14.00
15. 00   O1500   PHARMACY 16. 00   O1600   MEDI CAL RECORDS & LI BRARY	29, 295 11, 848	18, 821 35, 448	0	651 242	0	15. 00 16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	11, 040	33, 440	0	242	<u> </u>	10.00
30. 00 03000 ADULTS & PEDIATRICS	46, 759	356, 519	24, 078	21, 795	198, 445	30.00
31.00 03100 INTENSIVE CARE UNIT	17, 182	139, 781	5, 433	1, 454	52, 550	31.00
41. 00   04100   SUBPROVI DER -   RF	0	0	0	0	0	41.00
42. 00   04200   SUBPROVI DER	0	0	0	0	0	42.00
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	7, 749	36, 967	1, 989	288	0	43.00
50. 00 05000 OPERATI NG ROOM	37, 793	197, 496	21, 466	6, 467	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 830	18, 785			0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	26, 120	136, 420	8, 688	2, 226	0	54.00
57. 00   05700   CT   SCAN	4, 241	5, 277	0	0	0	57.00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	2, 775	6, 446 0		0	0	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	42, 770	99, 537	0 151	4, 846	0	59. 00 60. 00
60. 01   06001   BLOOD   LABORATORY	12,770	77, 337	0	0	0	60.01
65. 00 06500 RESPIRATORY THERAPY	6, 114	20, 917	0	1, 923	0	65.00
66. 00 06600 PHYSI CAL THERAPY	19, 511	13, 748			0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 147	1, 277	224	l .	0	67.00
68. 00   06800   SPEECH   PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY	822 2, 851	2, 325 0	0	_	0	68. 00 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 981	0	0	636	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	42, 303	0	l ő	ő	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	O	0	73.00
76. 00 03950 CARDI AC REHAB	2, 033	0	0	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS	40.750	0		٥	0	00.00
88.00   08800   NEW CASTLE FAMILY & INTERNAL MED 88.01   08801   NCFIM- NORTHFIELD PARK	49, 750 2, 201	0	0	0	0	88. 00 88. 01
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	2, 201	0	l ő	ő	0	89.00
91. 00 09100 EMERGENCY	40, 050	127, 335	21, 387	5, 861	0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	1/ /50			2 (((	0	101 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	16, 653	0	0	2, 666	0	101.00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
116. 00 11600 H0SPI CE	7, 790	0	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	536, 122	1, 526, 942	92, 668	62, 398	250, 995	118. 00
NONREIMBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	191	12, 158	0	424	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	17, 541	12, 130	59			190.00
194. 00 07950 HOSPI TALI ST	1, 587	0	0	ő		194.00
194. 01 07951 RENTAL	822	0	0	17, 856	0	194. 01
194. 02 07952 CMHS	0	0	0	0		194. 02
194. 03 07953 MCH	0	0	0	0		194. 03
194. 04 07954  WI C 194. 05 07955  OTHER NONREI MBURSABLE COSTS	0 1, 256	0	0 2, 528			194. 04 194. 05
194.06 07956 RHC- FOREST RIDGE	20, 700	0	742			194.05
194. 07 07957 PHI LLI PS HALL	20,700	0	970			194. 07
194. 08 07958 OB DRS	o	0	1, 602			194. 08
194.09 07959 THE WATERS	10, 002	0	20, 821	0		194. 09
194. 10 07960 CAMBRI DGE CITY	9, 451	0	0	0		194. 10
194. 11 07961 WELL BEING	6, 578	0	0	0		194. 11
194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC 194. 13 07963 NEW CASTLE PEDIATRICS	2, 702 51, 215	0	0			194. 12 194. 13
194. 14 07964 HENRY COUNTY RADI OLOGY	13, 538	0	0	ol		194. 14
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY	24, 818	0	0	o		194. 15
194.16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY	2, 095	0	0	0	0	194. 16
200.00 Cross Foot Adjustments		_	_	_	_	200.00
201.00   Negative Cost Centers 202.00   TOTAL (sum lines 118 through 201)	0 698, 618	0 1, 539, 100	119, 390	81, 768	0 250, 995	201.00
(SGIII   11100   110 till ough 201)	0,0,010	1,007,100	117, 370	01,700	200, 770	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0030

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Part II | Par

			10	12/31/2017	Date/lime Pre 5/30/2018 9:1	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2. 00   00200   NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4. 00 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 11. 00   01100   CAFETERI A	70, 638					10. 00 11. 00
13. 00   01300   NURSI NG   ADMI NI STRATI ON	4, 776	166, 115				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	2, 011	0	253, 913			14. 00
15. 00 01500 PHARMACY	0	0	591	83, 085		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	4, 022	0	609	0	116, 231	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS  30. 00 03000 ADULTS & PEDIATRICS	11, 564	53, 812	7, 452	O	11, 883	30. 00
31. 00   03100   NTENSI VE CARE UNIT	3, 519	16, 378	2, 200	0	5, 074	31.00
41. 00   04100   SUBPROVI DER -   RF	o	0	0	0	0	41.00
42. 00   04200   SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY	1, 760	8, 189	0	0	3, 438	43. 00
ANCILLARY SERVICE COST CENTERS  50. 00   05000   0PERATING ROOM	9, 301	43, 283	13, 337	0	19, 094	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	251	1, 170	0	Ö	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 782	O	5, 077	0	14, 287	54.00
57. 00   05700   CT   SCAN	503	0	1, 557	0	5, 107	57.00
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI) 59. 00   05900   CARDIAC CATHETERIZATION	503	0	633	0	1, 569 0	58. 00 59. 00
60. 00   06000 LABORATORY	8, 547	o	28, 187	0	18. 893	60.00
60. 01 06001 BLOOD LABORATORY	0	Ō	0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	1, 508	0	307	0	1, 402	65.00
66. 00 06600 PHYSI CAL THERAPY	6, 033	0	1, 438	0	1, 001	66.00
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	503 251	0	0	0	100 33	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	503	Ö	872	Ö	1, 068	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	42, 341	0	2, 670	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	138, 276	0	4, 707	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 00   03950   CARDIAC REHAB	0 754	3, 509	0 154	83, 085 0	0 134	73. 00 76. 00
OUTPATIENT SERVICE COST CENTERS	754	3, 307	154	<u> </u>	134	70.00
88. 00 08800 NEW CASTLE FAMILY & INTERNAL MED	0	0	1, 179	0	0	88. 00
88. 01   08801   NCFIM- NORTHFIELD PARK	0	0	258	0	0	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 91.00 09100 EMERGENCY	0 547	0  39, 774	7 972	0	0	89. 00 91. 00
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	8, 547	39, 774	7, 872	U	24, 569	91.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>					72.00
101.00 10100 HOME HEALTH AGENCY	0	0	859	0	701	101. 00
SPECIAL PURPOSE COST CENTERS		1				112 00
113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
116. 00 11600 HOSPI CE	o	o	713	0	501	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	70, 638	166, 115	253, 913	83, 085	116, 231	118. 00
NONREI MBURSABLE COST CENTERS	ا	ما	٥	ما	0	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		190. 00 192. 00
194. 00 07950 HOSPI TALI ST		ő	0	ő		194.00
194. 01 07951 RENTAL	o	0	0	0		194. 01
194. 02 07952 CMHS	0	0	0	0		194. 02
194. 03 07953 MCH 194. 04 07954 WI C	0	0	0	0		194. 03 194. 04
194. 05 07955 OTHER NONREIMBURSABLE COSTS		0	0	0		194. 04
194. 06 07956 RHC- FOREST RIDGE	Ö	Ö	Ö	Ö		194. 06
194. 07 07957 PHI LLI PS HALL	o	0	0	0		194. 07
194. 08 07958 OB DRS	0	0	0	0		194.08
194. 09 07959  THE WATERS 194. 10 07960  CAMBRI DGE CLTY	0	0	0	0		194. 09 194. 10
194. 10 07960 CAMBRIDGE CITY 194. 11 07961 WELL BEING		ol Ol	0	o n		194. 10 194. 11
194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC	o	ő	Ö	ő		194. 12
194. 13 07963 NEW CASTLE PEDIATRICS	0	o	0	o		194. 13
194. 14 07964 HENRY COUNTY RADI OLOGY	0	0	0	0		194. 14
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY 194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY		0	0	O O		194. 15 194. 16
200.00 Cross Foot Adjustments		Ĭ	o o			200. 00
201.00 Negative Cost Centers	o	O	0	O		201. 00

Health Fin	ancial Systems H	ENRY COUNTY MEM	IORI AL HOSPI TAL		In Lieu of Form CMS-2552-10			
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der CO		Peri od: From 01/01/2017	Worksheet B Part II		
					To 12/31/2017	Date/Time Pre 5/30/2018 9:1		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
			ADMI NI STRATI O	SERVICES &		RECORDS &		
			N	SUPPLY		LI BRARY		
		11. 00	13. 00	14. 00	15. 00	16.00		
202 00	TOTAL (sum Linos 110 through 201)	70 629	166 115	252 01	3 03 005	116 221	202 00	

70, 638

166, 115

TOTAL (sum lines 118 through 201)

202. 00

116, 231 202. 00

253, 913

83, 085

| Period: | Worksheet B | From 01/01/2017 | Part II | To | 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0030

					To 12/31/2017 Date/Time Pr 5/30/2018 9:	
	Cost Center Description	Subtotal	Intern &	Total	3/30/2016 9.	13 dili
			Residents Cost & Post			
			Stepdown			
		24. 00	Adjustments	24 00		
	GENERAL SERVICE COST CENTERS	24.00	25. 00	26. 00		
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT					1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
5. 00	00500 ADMINI STRATI VE & GENERAL					5.00
7.00	00700 OPERATION OF PLANT					7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING					8. 00 9. 00
10. 00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY					13. 00 14. 00
	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS   03000   ADULTS & PEDIATRICS	1, 373, 419	0	1, 373, 41	9	30.00
	03100 I NTENSI VE CARE UNI T	494, 861	0	1		31.00
	04100 SUBPROVI DER - I RF	0	0	1	0	41.00
	04200 SUBPROVI DER 04300 NURSERY	0 127, 012	0	1	0	42. 00 43. 00
.0.00	ANCILLARY SERVICE COST CENTERS	127,012	<u> </u>			10.00
50.00	05000 OPERATING ROOM	703, 786	0			50.00
52. 00 54. 00	05200   DELIVERY ROOM & LABOR ROOM   05400   RADIOLOGY-DIAGNOSTIC	56, 200 444, 202	0			52.00 54.00
57. 00	05700 CT SCAN	26, 255	0			57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	23, 548	0	1	18	58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 382, 648	0	1	0 18	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0	0		0	60.01
65. 00	06500 RESPIRATORY THERAPY	69, 948	0			65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	78, 167 7, 496	0	1		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	7, 644	0	1 .,		68.00
	06900 ELECTROCARDI OLOGY	6, 031	0			69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	57, 992 185, 286	0			71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	83, 085	0	83, 08		73. 00
76. 00	03950 CARDIAC REHAB OUTPATIENT SERVICE COST CENTERS	22, 041	0	22, 04	<u>+1 </u>	76.00
88. 00	08800 NEW CASTLE FAMILY & INTERNAL MED	53, 422	0	53, 42	22	88.00
88. 01	08801 NCFIM- NORTHFIELD PARK	2, 554	0	2, 55		88. 01
89. 00 91. 00	08900  FEDERALLY QUALIFIED HEALTH CENTER 09100  EMERGENCY	0 505, 299	0	1	0	89. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	505, 299	0		'9	91.00
	OTHER REIMBURSABLE COST CENTERS					
101. 00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	21, 702	0	21, 70	12	101.00
113. 00	11300 I NTEREST EXPENSE					113.00
	11400 UTILIZATION REVIEW-SNF					114.00
116.00	11600 HOSPICE   SUBTOTALS (SUM OF LINES 1 through 117)	9, 294 4, 741, 892	0	1		116. 00 118. 00
	NONREI MBURSABLE COST CENTERS	1,711,072	<u> </u>			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	32, 239	0			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 HOSPI TALI ST	18, 276 1, 591	0	1		192. 00 194. 00
194. 01	07951 RENTAL	59, 558	0	1		194. 01
	07952 CMHS	0	0		0	194.02
	07953 MCH 07954 WI C	0	0	1	0	194. 03 194. 04
194. 05	07955 OTHER NONREIMBURSABLE COSTS	3, 784	0	3, 78		194. 05
	07956 RHC- FOREST RIDGE	22, 372	0	,		194.06
	07957 PHILLIPS HALL 07958 OB DRS	2, 060 1, 602	0			194. 07 194. 08
194. 09	07959 THE WATERS	560, 726	0	560, 72	26	194. 09
	07960 CAMBRI DGE CI TY	9, 880	0			194. 10
	07961 WELL BEING 07962 ACTIVATE HEALTH EMPLOYER CLINIC	6, 878 2, 808	0	-,		194. 11 194. 12
194. 13	07963 NEW CASTLE PEDIATRICS	53, 634	0	53, 63	34	194. 13
	07964 HENRY COUNTY RADIOLOGY	13, 656	0	1		194. 14
	07965 HENRY COUNTY ANESTHESIOLOGY 07966 NEW CASTLE IMMEDICATE CARE & FAMILY	26, 101 2, 180	0			194. 15 194. 16
	in the state of the different court of the di	2, 150		2,10	1	1

Health Financial Systems	HENRY COUNTY MEN	HENRY COUNTY MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provider Co	CN: 15-0030	Peri od: From 01/01/2017 To 12/31/2017			
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total				
	24. 00	25. 00	26. 00				
200.00 Cross Foot Adjustments	0	0		0	200.00		
201.00 Negative Cost Centers	0	0		0	201.00		
202.00   TOTAL (sum lines 118 through 201)	5, 559, 237	0	5, 559, 2	37	202.00		

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0030 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/30/2018 9:13 am CAPITAL RELATED COSTS Reconciliatio ADMINISTRATIV Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE FOULP** BENEFITS E & GENERAL FI XT n (SQUARE (SQUARE DEPARTMENT (ACCUM. FEET) FEET) (GROSS COST) SALARI ES) 1. 00 2.00 4.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 255, 678 1 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 272, 444 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 361 38, 244, 709 4.00 4.00 1.361 5.00 00500 ADMINISTRATIVE & GENERAL 5, 432, 896 71, 019, 475 32, 161 5.00 32, 161 -14, 162, 750 7.00 00700 OPERATION OF PLANT 69, 176 69, 176 1, 092, 807 4, 532, 957 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 3, 421 3, 421 0 437, 304 8.00 1, 987 963, 209 00900 HOUSEKEEPI NG 1, 987 495, 830 0 9.00 9 00 01000 DI ETARY 0 10.00 7, 218 7, 218 212, 538 497, 244 10.00 11.00 01100 CAFETERI A 1, 972 1, 972 301, 860 322, 365 11.00 01300 NURSING ADMINISTRATION 0 13.00 3, 964 3, 964 1,677,682 2, 592, 229 13.00 01400 CENTRAL SERVICES & SUPPLY 1,080,019 14 00 7 153 7.153 440, 114 14 00 15.00 01500 PHARMACY 1,562 1,562 0 0 2, 978, 004 15.00 01600 MEDICAL RECORDS & LIBRARY 700, 065 1, 204, 440 16.00 2.942 2.942 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 29 589 29 589 2 886 811 0 4 753 423 30.00 31.00 03100 INTENSIVE CARE UNIT 11,601 11,601 1,038,837 0 1, 746, 640 31.00 04100 SUBPROVI DER - I RF 41.00 0 41.00 0 C 0 04200 SUBPROVI DER 42 00 O 0 42 00 0 0 04300 NURSERY 43.00 3,068 3,068 504, 498 0 787, 780 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 16, 391 16, 391 2, 121, 068 0 3, 841, 970 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 1.559 106, 505 185, 986 1, 559 52 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 322 11, 322 1, 476, 539 2, 655, 293 54.00 147, 179 05700 CT SCAN 0 431, 093 57.00 438 438 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 535 535 92, 102 282, 082 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 0 0 0 59 00 o 60.00 06000 LABORATORY 8, 261 8, 261 1, 748, 885 4, 347, 904 60.00 06001 BLOOD LABORATORY 0 60.01 0 60.01 0 65.00 06500 RESPIRATORY THERAPY 1,736 380, 632 621, 503 65.00 1.736 06600 PHYSI CAL THERAPY 66.00 1.141 1, 141 1, 346, 716 1, 983, 422 66 00 160, 606 0 06700 OCCUPATI ONAL THERAPY 106 106 218, 245 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 193 193 58, 991 0 0 83,600 68.00 289, 786 06900 ELECTROCARDI OLOGY 131, 065 69.00 69.00 0 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 C 0 1, 319, 615 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 4, 300, 382 72.00 07300 DRUGS CHARGED TO PATIENTS 0 o 73.00 73.00 0 0 03950 CARDI AC REHAB 711 0 206, 653 76.00 711 136, 830 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 NEW CASTLE FAMILY & INTERNAL MED 3, 245, 765 5, 057, 391 88.00 08801 NCFIM- NORTHFIELD PARK 0 223, 752 88.01 0 C 123, 472 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 0 0 0 Ω 89.00 91.00 09100 EMERGENCY 10, 568 10,568 2, 234, 505 0 4,071,380 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 1, 071, 897 0 1, 692, 883 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 377, 156 791, 904 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 230, 136 230, 136 118.00 29, 743, 851 -14, 162, 750 54, 500, 458 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,009 19, 466 190.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 879, 634 0 1, 783, 124 192. 00 194. 00 07950 HOSPI TALI ST 0 0 4,813 161, 356 194. 00 C o 83, 549 194. 01 194. 01 07951 RENTAL 0 17, 775 0 194. 02 07952 CMHS 0 0 0 194. 02 0 194. 03 07953 MCH 0 0 0 0 194.03 0 0 194. 04 07954 WI C 0 0 0 0 0 194.04 0 127, 698 194. 05 194. 05 07955 OTHER NONREI MBURSABLE COSTS C 194. 06 07956 RHC- FOREST RIDGE 0 C 1, 211, 336 2, 104, 307 194. 06 194. 07 07957 PHI LLI PS HALL 0 0 0 194.07 0 194.08 07958 OB DRS 0 0 194.08 0 194. 09 07959 THE WATERS 24.533 24, 533 232, 781 1, 016, 732 194. 09 194. 10 07960 CAMBRI DGE CITY 559,083 960, 807 194. 10 194. 11 07961 WELL BEING 0 0 390, 394 0 668, 661 194. 11 194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC 0 0 274, 654 194. 12 0 138, 635 194. 13 07963 NEW CASTLE PEDIATRICS 0 0 3, 149, 763 5, 206, 596 194. 13

153, 012

1, 376, 204 194. 14

194. 14 07964 HENRY COUNTY RADIOLOGY

Peri od: Worksheet B-1 From 01/01/2017 To 12/31/2017 Date/Time Prepared:

						5/30/2018 9:1	3 am
		CAPITAL RELA	ATED COSTS				
		NEW DIDO :	NEW 18/51 E	5451 0VEE			
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE		ADMI NI STRATI V	
		FLXT	EQUI P	BENEFITS	n	E & GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
		1.00		SALARI ES)			
		1. 00	2. 00	4.00	5A	5. 00	
	HENRY COUNTY ANESTHESI OLOGY	0	0	1, 670, 643		2, 522, 938	
	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	110, 764	0	212, 925	
200. 00	Cross Foot Adjustments					ł	200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	4, 932, 660	626, 577	10, 461, 885		14, 162, 750	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	19. 292469	2. 299838	0. 273551		0. 199421	203. 00
204.00	Cost to be allocated (per Wkst. B,			29, 387		698, 618	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part			0. 000768		0. 009837	205. 00
	[1]						
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)						

		HENRY COUNTY MEN				Wastabaat D 1	
COST	ALLOCATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 01/01/2017 o 12/31/2017	Worksheet B-1 Date/Time Pre 5/30/2018 9:1	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERI A (FTE' S)	o um
		7. 00	8. 00	9.00	10.00	11.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	127, 736 3, 421 1, 987 7, 218 1, 972 3, 964 7, 153 1, 562 2, 942	705, 361 29, 931 8, 039 0 0	5, 399 116 59 79 20 43	7, 857 0 0 0 0	281 19 8 0	13. 00 14. 00 15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	T	I	1			
30. 00 31. 00 41. 00 42. 00 43. 00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	29, 589 11, 601 0 0 3, 068	32, 100 0 0	96 0 0	1, 645 0 0	46 14 0 0 7	31.00
50. 00		16, 391	126, 819	427	O	37	50.00
52. 00 54. 00 57. 00 58. 00 59. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	1, 559 11, 322 438 535	2, 481 51, 328 0 0 0	0 147 0 0 0	0 0 0 0	1 23 2 2 0	52. 00 54. 00 57. 00 58. 00 59. 00
60.00	06000 LABORATORY	8, 261	892			34	60.00
60. 01 65. 00 66. 00 67. 00 68. 00	06700 OCCUPATI ONAL THERAPY	0 1, 736 1, 141 106 193	0 14, 209 1, 325	127 552 55	0	0 6 24 2	1
69. 00 71. 00 72. 00 73. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 0	0 0 0	42 0 0	0	2 0 0	69. 00 71. 00
76. 00	03950 CARDI AC REHAB	0	0	0	0	3	76.00
00 NN	OUTPATIENT SERVICE COST CENTERS 08800 NEW CASTLE FAMILY & INTERNAL MED	1 0	0	Ιο	O	0	88.00
88. 01 89. 00 91. 00	08801 NCFIM- NORTHFIELD PARK	0 0 0 10, 568	0	0	0	0	88. 01
	OTHER REIMBURSABLE COST CENTERS						
101.00	0 10100 HOME HEALTH AGENCY	0	0	176	0	0	101.00
114.00	SPECIAL PURPOSE COST CENTERS D 11300 INTEREST EXPENSE D 11400 UTILIZATION REVIEW-SNF D 11600 HOSPICE		0	0	0	0	113. 00 114. 00 116. 00
118.00	l l	126, 727	547, 487	4, 120	7, 857		118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	1, 009 0	0 350				190. 00 192. 00
	007950 H0SPI TALI ST 107951 RENTAL	0	0	0 1, 179	_		194. 00 194. 01
	2 07952 CMHS	0	0	0	· ·		194. 02
	3 07953  MCH 4 07954  WI C	0	0	0	· ·		194. 03 194. 04
	5 07955 OTHER NONREI MBURSABLE COSTS	Ö	14, 936		· ·		194. 05
	6 O7956 RHC- FOREST RIDGE 7 O7957 PHILLIPS HALL	0	4, 385				194. 06 194. 07
	8 07958 OB DRS	0	5, 728 9, 465				194. 07
	9 07959 THE WATERS	0	123, 010	0	0		194. 09
	DO7960 CAMBRIDGE CITY 1 07961 WELL BEING	0	0		0		194. 10 194. 11
194. 12	2 07962 ACTIVATE HEALTH EMPLOYER CLINIC	0	o	0	0	0	194. 12
	3 07963 NEW CASTLE PEDIATRICS 4 07964 HENRY COUNTY RADIOLOGY	0	0	0	0		194. 13 194. 14
194. 1	507965 HENRY COUNTY ANESTHESIOLOGY 607966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0 0	0	0	194. 14 194. 15 194. 16 200. 00
	· · · · · ·						-

Heal th Fi	nancial Systems HE	ENRY COUNTY MEN	ORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLO	OCATION - STATISTICAL BASIS	Provi der CCN: 15-0030			Peri od:	Worksheet B-1	
					From 01/01/2017 To 12/31/2017		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		PLANT	LINEN SERVICE	(HOURS OF	(PATI ENT	(FTE' S)	
		(SQUARE	(POUNDS OF	SERVI CE)	DAYS)		
		FEET)	LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	5, 436, 924	670, 123	1, 268, 30	3 938, 517	484, 447	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	42. 563756	0. 950043	234. 91442	9 119. 449790	1, 724. 010676	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1, 539, 100	119, 390	81, 76	8 250, 995	70, 638	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	12. 049070	0. 169261	15. 14502	7 31. 945399	251. 380783	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
ı	1 ,	1	1	ı	1	1	1

COST ALLOCATION - STATISTICAL BASIS  Provider CCN: 15-0030   Period:   From 01/01/2017	Worksheet B-1
To 12/31/2017	Date/Time Prepared:
	5/30/2018 9: 13 am
Cost Center Description   NURSING   CENTRAL   PHARMACY   MEDICAL   ADMINISTRATIO   SERVICES & (COSTED   RECORDS &	
N SUPPLY REQUIS.) LIBRARY	
(DIRECT (COSTED (TIME	
NRSING HRS) REQUIS.) SPENT)	
13. 00   14. 00   15. 00   16. 00	
GENERAL SERVICE COST CENTERS  1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT	1.00
1. 00   00100  NEW CAP REL COSTS-BLDG & FIXT 2. 00   00200  NEW CAP REL COSTS-MVBLE EQUIP	1.00
4. 00   00400  EMPLOYEE BENEFITS DEPARTMENT	4.00
5. 00   00500  ADMI NI STRATI VE & GENERAL	5. 00
7. 00 00700 OPERATION OF PLANT	7.00
8.00   00800   LAUNDRY & LINEN SERVICE	8. 00
9. 00   00900   HOUSEKEEPI NG	9.00
10. 00   01000   DI ETARY	10.00
11. 00   01100   CAFETERI A	11.00
13. 00   01300   NURSI NG   ADMI NI STRATI ON   142   14. 00   01400   CENTRAL   SERVI CES & SUPPLY   0   7, 896, 696	13.00
15. 00   01500   PHARMACY	15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY   0   18, 946   0   3, 482	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 46 231, 762 0 356	30.00
31. 00   03100   I NTENSI VE CARE UNI T 14 68, 416 0 152	31.00
41. 00   04100   SUBPROVI DER -   RF   0   0   0	41.00
42. 00   04200  SUBPROVI DER	42.00
43. 00   04300  NURSERY   7   0   0   103	43.00
50. 00   05000   0PERATI NG ROOM   37   414, 796   0   572	50.00
52. 00   05200  DELIVERY ROOM & LABOR ROOM 1 0 0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0   157, 891   0   428	54.00
57. 00   05700   CT SCAN   0   48, 427   0   153	57.00
58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI)   0   19, 702   0   47	58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON	59.00
60. 00   06000   LABORATORY   0   876, 617   0   566   60. 01   06001   BLOOD   LABORATORY   0   0   0	60.00
65. 00   06500   RESPI RATORY THERAPY	65. 00
66. 00   06600  PHYSI CAL THERAPY	66.00
67. 00   06700   OCCUPATI ONAL THERAPY   0   0   3	67. 00
68. 00   06800   SPEECH PATHOLOGY   0   21   0   1	68.00
69. 00   06900   ELECTROCARDI OLOGY   0   27, 107   0   32	69.00
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   1,316,807   0   80   141	71.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0   4, 300, 382   0   141   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   100   0	72. 00 73. 00
76. 00   03950   CARDI AC REHAB   3   4, 799   0   4	76.00
OUTPATIENT SERVICE COST CENTERS	
88. 00 08800 NEW CASTLE FAMILY & INTERNAL MED 0 36, 675 0 0	88. 00
88. 01   08801   NCFIM- NORTHFIELD PARK   0   8, 019   0	88. 01
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   0   0	89.00
91. 00   09100   EMERGENCY   34   244, 825   0   736   92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)	91.00
OTHER REIMBURSABLE COST CENTERS	72.00
101. 00 10100 HOME HEALTH AGENCY 0 26, 715 0 21	101. 00
SPECIAL PURPOSE COST CENTERS	
113. 00 11300 I NTEREST EXPENSE	113.00
114.00 11400 UTILI ZATION REVIEW-SNF	114. 00
116.00   11600   HOSPICE 0 22,174 0 15   118.00   SUBTOTALS (SUM OF LINES 1 through 117) 142 7,896,696 100 3,482	116.00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   142   7,896,696   100   3,482   NONREI MBURSABLE COST CENTERS	118. 00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 0	192. 00
194. 00 07950 H0SPI TALI ST 0 0 0 0	194. 00
194. 01 07951 RENTAL 0 0 0 0	194. 01
194. 02 07952 CMHS 0 0 0 0	194. 02
194. 03 07953 MCH 0 0 0	194. 03
194. 04 07954 WI C 0 0 0 0 0 0 194. 05 07955 OTHER NONREI MBURSABLE COSTS 0 0 0 0	194. 04 194. 05
194. 06 07956 RHC- FOREST RIDGE 0 0 0	194.06
194. 07 07957  PHI LLI PS HALL 0 0 0 0	194. 07
194. 08 07958 OB DRS 0 0 0	194. 08
194. 09 07959 THE WATERS 0 0 0 0	194. 09
194. 10 07960 CAMBRI DGE CITY 0 0 0	194. 10
194. 11 07961 WELL BEING 0 0 0	194. 11
194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC 0 0 0	194. 12
194. 13 07963  NEW CASTLE PEDI ATRI CS 0 0 0 0 0 194. 14 07964  HENRY COUNTY RADI OLOGY 0 0 0	194. 13 194. 14
194. 14 07964 HENRY COUNTY RADIOLOGY 0 0 0 0 0	194. 14
194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY 0 0 0	194. 16
	•

Health F	inancial Systems H	ENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-	-2552-10
COST ALI	LOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-	1
					From 01/01/2017 To 12/31/2017	Date/Time Pr 5/30/2018 9:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &		
		N N	SUPPLY	REQUIS.)	LI BRARY		
		(DI RECT	(COSTED		(TIME		
		NRSI NG HRS)	REQUIS.)		SPENT)		
		13. 00	14. 00	15. 00	16. 00		
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	3, 329, 211	1, 618, 346	3, 652, 23	1, 605, 080		202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	23, 445. 147887	0. 204940	36, 522. 32000	460. 964963		203.00
204. 00	Cost to be allocated (per Wkst. B, Part II)	166, 115	253, 913	83, 08	116, 231		204. 00
205.00	Unit cost multiplier (Wkst. B, Part	1, 169. 823944	0. 032154	830. 85000	33. 380528		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0030	Peri od:	Worksheet C

From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared: 5/30/2018 9:13 am Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs (from Wkst. Adj Di sal I owance B, Part I, col. 26) 1. 00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 545, 371 9, 545, 371 0 9, 545, 371 30.00 03100 INTENSIVE CARE UNIT 3, 274, 738 3, 274, 738 0 3, 274, 738 31.00 31.00 41.00 04100 SUBPROVI DER - I RF 0 0 41.00 0 04200 SUBPROVI DER 42.00 0 0 0 42.00 1, 314, 755 43.00 04300 NURSERY 1, 314, 755 1, 314, 755 43.00 ANCILLARY SERVICE COST CENTERS 6, 806, 532 6, 806, 532 50.00 05000 OPERATING ROOM 6, 806, 532 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 316, 959 316, 959 316, 959 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 019, 320 4,019,320 0 4, 019, 320 54.00 57.00 05700 CT SCAN 619, 606 619, 606 o 619, 606 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 390, 258 0 58.00 390, 258 390, 258 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 0 0 0 0 59.00 06000 LABORATORY 6, 144, 071 60.00 6, 141, 782 6, 141, 782 2.289 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06500 RESPIRATORY THERAPY 880, 828 0 880, 828 65.00 880, 828 65.00 66.00 06600 PHYSI CAL THERAPY 2, 635, 063 0 2, 635, 063 0 2, 635, 063 66.00 06700 OCCUPATI ONAL THERAPY 285, 290 285, 290 o 285, 290 67.00 67.00 o 06800 SPEECH PATHOLOGY 68.00 110,676 110, 676 110, 676 68.00 0 69.00 06900 ELECTROCARDI OLOGY 381, 195 381, 195 381, 195 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,889,517 1, 889, 517 0 1, 889, 517 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 6, 104, 283 6, 104, 283 6, 104, 283 72.00 ol 73 00 07300 DRUGS CHARGED TO PATIENTS 3, 652, 232 3, 652, 232 3, 652, 232 73 00 03950 CARDI AC REHAB 76.00 326, 199 326, 199 0 326, 199 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 NEW CASTLE FAMILY & INTERNAL MED 6, 073, 457 6, 073, 457 ol 6, 073, 457 88.00 08801 NCFIM- NORTHFIELD PARK 0 88.01 270, 016 270, 016 270, 016 88.01 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 91.00 09100 EMERGENCY 6, 789, 263 6, 789, 263 0 6, 789, 263 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 235, 979 1, 235, 979 <u>1, 235, 97</u>9 92 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 2, 086, 979 2, 086, 979 2, 086, 979 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 961, 284 116. 00 961, 284 961, 284 200.00 Subtotal (see instructions) 66, 111, 582 0 66, 111, 582 2.289 66, 113, 871 200. 00 1, 235, 979 201. 00 1, 235, 979 201.00 Less Observation Beds 1, 235, 979 202.00 Total (see instructions) 64, 875, 603 0 64, 875, 603 2, 289 64, 877, 892 202. 00

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0030 Peri od: Worksheet C From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 9:13 am Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9 880 714 9 880 714 30.00 31.00 03100 INTENSIVE CARE UNIT 4, 928, 159 4, 928, 159 31.00 04100 SUBPROVI DER - I RF 41.00 41.00 0 42.00 04200 SUBPROVI DER 0 0 42.00 04300 NURSERY 2, 121, 872 2, 121, 872 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 7,060,985 14, 341, 724 21, 402, 709 0.318022 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0. 196522 884.361 728, 478 1, 612, 839 0.000000 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 1, 717, 654 14, 560, 138 16, 277, 792 0.246920 54 00 57.00 05700 CT SCAN 1, 711, 824 19, 507, 216 21, 219, 040 0.029200 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 226, 830 5, 895, 250 6, 122, 080 0.063746 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0.000000 59 00 59 00 0 60.00 06000 LABORATORY 4, 724, 293 20, 243, 646 24, 967, 939 0.245987 0.000000 60.00 06001 BLOOD LABORATORY 0.000000 60.01 0.000000 60.01 06500 RESPIRATORY THERAPY 3, 743, 598 1, 675, 131 5, 418, 729 0.000000 0.162553 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 494, 684 3, 374, 854 3, 869, 538 0.680976 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 353, 239 360, 914 0.790465 0.000000 67.00 7,675 67.00 68.00 06800 SPEECH PATHOLOGY 24, 652 109, 763 134, 415 0.823390 0.000000 68.00 06900 ELECTROCARDI OLOGY 4, 150, 887 0.091835 69.00 945, 220 3, 205, 667 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 892, 339 6, 437, 887 10, 330, 226 0.182911 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 12, 969, 991 5, 263, 627 18, 233, 618 0.334782 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 308, 760 4, 032, 173 8, 340, 933 0.437869 0.000000 73.00 73.00 03950 CARDI AC REHAB 76.00 0 492, 509 492, 509 0.662321 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 08800 NEW CASTLE FAMILY & INTERNAL MED

08801 NCFIM- NORTHFIELD PARK 0 88.01 730, 683 730, 683 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 89.00 91.00 09100 EMERGENCY 1, 336, 610 14, 780, 046 16, 116, 656 0.421258 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 386, 308 883, 973 1, 270, 281 0.972997 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 2, 723, 167 2, 723, 167 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114 00 116. 00 11600 HOSPI CE 1,878,397 1, 878, 397 116.00 200.00 Subtotal (see instructions) 185, 722, 855 200.00 61, 366, 529 124, 356, 326 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 61, 366, 529 124, 356, 326 185, 722, 855 202.00

3, 138, 758

3, 138, 758

88.00

88.00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0030	From 01/01/2017	Worksheet C Part I Date/Time Prepared:

					5/30/2018 9:13 am
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVI DER - I RF				41.00
42.00	04200 SUBPROVI DER				42.00
43.00	04300 NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 318022			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 196522			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 246920			54.00
57.00	05700 CT SCAN	0. 029200			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 063746			58.00
59.00	1 1	0. 000000			59.00
60.00	06000 LABORATORY	0. 246078			60.00
60. 01	06001 BLOOD LABORATORY	0. 000000			60. 01
65.00	06500 RESPIRATORY THERAPY	0. 162553			65.00
66.00	06600 PHYSI CAL THERAPY	0. 680976			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 790465			67.00
	06800 SPEECH PATHOLOGY	0. 823390			68.00
69.00	06900 ELECTROCARDI OLOGY	0. 091835			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 182911			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 334782			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 437869			73.00
76.00	03950 CARDI AC REHAB	0. 662321			76.00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>			
88. 00	08800 NEW CASTLE FAMILY & INTERNAL MED				88.00
88. 01	08801 NCFIM- NORTHFIELD PARK				88. 01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
91.00	09100 EMERGENCY	0. 421258			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 972997			92.00
	OTHER REIMBURSABLE COST CENTERS	'			
101.0	10100 HOME HEALTH AGENCY				101. 00
	SPECIAL PURPOSE COST CENTERS				
113.0	11300 INTEREST EXPENSE				113. 00
114.0	0 11400 UTILIZATION REVIEW-SNF				114.00
116.0	0 11600 HOSPI CE				116.00
200.0	Subtotal (see instructions)				200. 00
201.0	Less Observation Beds				201.00
202.0	Total (see instructions)				202. 00

From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 9:13 am Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 545, 371 9, 545, 371 0 9, 545, 371 30.00 03100 INTENSIVE CARE UNIT 3, 274, 738 3, 274, 738 0 3, 274, 738 31.00 31.00 41.00 04100 SUBPROVI DER - I RF 0 0 41.00 0 0 04200 SUBPROVI DER 42.00 0 0 0 42.00 1, 314, 755 1, 314, 755 43.00 04300 NURSERY 1, 314, 755 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 6, 806, 532 6, 806, 532 6, 806, 532 50.00 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 316, 959 316, 959 316, 959 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 019, 320 4,019,320 0 4, 019, 320 54.00 57.00 05700 CT SCAN 619, 606 619, 606 o 619, 606 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 390, 258 0 58.00 390, 258 390, 258 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 0 0 0 0 59.00 06000 LABORATORY 6, 141, 782 6, 141, 782 6, 144, 071 60.00 2.289 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 0 06500 RESPIRATORY THERAPY 880, 828 880.828 0 880, 828 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 2, 635, 063 0 2, 635, 063 0 2, 635, 063 66.00 06700 OCCUPATI ONAL THERAPY 285, 290 285, 290 0 285, 290 67.00 67.00 o 06800 SPEECH PATHOLOGY 68.00 110,676 110, 676 110, 676 68.00 06900 ELECTROCARDI OLOGY 0 69.00 381, 195 381, 195 381, 195 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,889,517 1, 889, 517 0 1, 889, 517 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 6, 104, 283 6, 104, 283 6, 104, 283 72.00 ol 73 00 07300 DRUGS CHARGED TO PATIENTS 3, 652, 232 3, 652, 232 3, 652, 232 73 00 03950 CARDI AC REHAB 76.00 326, 199 326, 199 0 326, 199 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 NEW CASTLE FAMILY & INTERNAL MED 6, 073, 457 6, 073, 457 ol 6, 073, 457 88.00 08801 NCFLM- NORTHFLELD PARK 0 88.01 270, 016 270, 016 270, 016 88.01 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 09100 EMERGENCY 91.00 6, 789, 263 6, 789, 263 0 6, 789, 263 91.00 <u>1, 235, 97</u>9 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 235, 979 1, 235, 979 92 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 2, 086, 979 2, 086, 979 2, 086, 979 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 961, 284 116. 00 961, 284 961, 284 200.00 Subtotal (see instructions) 66, 111, 582 0 66, 111, 582 2.289 66, 113, 871 200. 00

1 235 979

64, 875, 603

1, 235, 979 201. 00

64, 877, 892 202. 00

2, 289

1, 235, 979

64, 875, 603

0

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES In Lieu of Form CMS-2552-10 Peri od: Worksheet C From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 9:13 am Provider CCN: 15-0030

					5/30/2018 9:1	3 am	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
	'	'	•	+ col. 7)	Ratio	I npati ent	
				,		Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1 2. 2. 1					
	03000 ADULTS & PEDI ATRI CS	9, 880, 714		9, 880, 7	4		30.00
	03100   NTENSI VE CARE UNI T	4, 928, 159		4, 928, 15			31.00
	04100 SUBPROVI DER - I RF	4, 720, 137		4, 720, 10	0		41.00
	04200 SUBPROVI DER						42.00
	04300 NURSERY	2, 121, 872		2, 121, 8	12		43.00
	ANCILLARY SERVICE COST CENTERS	2, 121, 0/2		2, 121, 0	2		43.00
	05000 OPERATING ROOM	7 0/0 005	14 241 724	21 402 7	0. 318022	0. 000000	50.00
		7, 060, 985	14, 341, 724				
	05200 DELIVERY ROOM & LABOR ROOM	884, 361	728, 478			0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	1, 717, 654	14, 560, 138			0. 000000	
	05700 CT SCAN	1, 711, 824	19, 507, 216			0. 000000	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	226, 830	5, 895, 250			0. 000000	1
	05900 CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0. 000000	
60.00	06000 LABORATORY	4, 724, 293	20, 243, 646	24, 967, 93		0. 000000	
	06001 BLOOD LABORATORY	0	0		0. 000000	0. 000000	
65.00	06500 RESPI RATORY THERAPY	3, 743, 598	1, 675, 131	5, 418, 72	9 0. 162553	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	494, 684	3, 374, 854	3, 869, 53	0. 680976	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	7, 675	353, 239	360, 9°	4 0. 790465	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	24, 652	109, 763	134, 4°	5 0. 823390	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	945, 220	3, 205, 667	4, 150, 88	0. 091835	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 892, 339	6, 437, 887			0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENT	12, 969, 991	5, 263, 627			0.000000	
	07300 DRUGS CHARGED TO PATIENTS	4, 308, 760	4, 032, 173			0.000000	
	03950 CARDI AC REHAB	0	492, 509			0. 000000	1
	OUTPATIENT SERVICE COST CENTERS	<u> </u>	1,2,00,	1,2,0	0.002021	0.00000	1 / 0. 00
	08800 NEW CASTLE FAMILY & INTERNAL MED	0	3, 138, 758	3, 138, 75	1. 934987	0. 000000	88. 00
	08801 NCFIM- NORTHFIELD PARK		730, 683			0. 000000	
	08900 FEDERALLY QUALIFIED HEALTH CENTER		730,009		0.000000	0. 000000	
	09100 EMERGENCY	1, 336, 610	14, 780, 046	1		0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1					1
		386, 308	883, 973	1, 270, 28	0. 972997	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS		2 722 1/7	2 722 1	7		101 00
101.00	10100 HOME HEALTH AGENCY	0	2, 723, 167	2, 723, 10	0/		101.00
	SPECIAL PURPOSE COST CENTERS			1			4
	11300 I NTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF						114.00
	11600 H0SPI CE	0	1, 878, 397				116. 00
200.00	, ,	61, 366, 529	124, 356, 326	185, 722, 85	55		200.00
201.00							201.00
202.00	Total (see instructions)	61, 366, 529	124, 356, 326	185, 722, 85	55		202.00
							•

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0030	Peri od: Worksheet C From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared: 5/30/2018 9:13 am

				1.0 12,01,201,	5/30/2018 9: 13 am
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVI DER - I RF				41.00
42.00	04200 SUBPROVI DER				42.00
43.00	04300 NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS	,			
50.00	05000 OPERATING ROOM	0. 000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57.00	05700 CT SCAN	0. 000000			57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
	06000 LABORATORY	0. 000000			60.00
	06001 BLOOD LABORATORY	0. 000000			60. 01
	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
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
	03950 CARDI AC REHAB	0. 000000			76.00
	OUTPATIENT SERVICE COST CENTERS	0.000000			70.00
	08800 NEW CASTLE FAMILY & INTERNAL MED	0. 000000			88.00
	08801 NCFIM- NORTHFIELD PARK	0. 000000			88. 01
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.00
	09100 EMERGENCY	0. 000000			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
	OTHER REIMBURSABLE COST CENTERS	0.00000			72.00
	10100 HOME HEALTH AGENCY				101.00
	SPECIAL PURPOSE COST CENTERS				.000
113.00	11300 I NTEREST EXPENSE				113. 00
	11400 UTILIZATION REVIEW-SNF				114.00
	11600 HOSPI CE				116.00
200. 00					200. 00
201.00					201.00
202. 00					202. 00
_000	1.2.2. (000 1.101. 401.01.0)	1			1202.00

		ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co	F	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part I Date/Time Pre 5/30/2018 9:1	pared: 3 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col . 2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 373, 419	0	1, 373, 419	7, 136	192. 46	30.00
31. 00 INTENSIVE CARE UNIT	494, 861		494, 861	1, 645	300. 83	31.00
41. 00 SUBPROVI DER - I RF	0	0	l	o	0.00	41.00
42. 00 SUBPROVI DER	0	0	l	o	0.00	42.00
43. 00 NURSERY	127, 012		127, 012	720	176. 41	43.00
200.00 Total (lines 30 through 199)	1, 995, 292		1, 995, 292	9, 501		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 & PEDIATRICS	3, 056	588, 158				30.00
31. 00 INTENSIVE CARE UNIT	974	293, 008				31.00
41. 00 SUBPROVI DER - I RF	0	0				41.00
42. 00 SUBPROVI DER	0	0				42.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	4, 030	881, 166				200. 00

Health Financial Systems	HENRY COUNTY MEMORI	HENRY COUNTY MEMORIAL HOSPITAL		u of Form CMS-2552-10
ADDODEL ONMENT OF LANDATIENT	ANOLILIADY CEDVIOR CARLEAU COCTO	D 1 L . OON 45 0000	D	West states to D

Health Financial Systems H	ENRY COUNTY MEN	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 9:1	pared: 3 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col . 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	700 701			0 (70 070	07.000	
50. 00   05000   OPERATING ROOM	703, 786					
52. 00   05200   DELI VERY ROOM & LABOR ROOM	56, 200		l .		<b>l</b>	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	444, 202					54.00
57. 00   05700   CT   SCAN	26, 255					57.00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	23, 548	6, 122, 080			l	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59.00
60. 00   06000   LABORATORY	382, 648				1	60.00
60. 01   06001   BLOOD   LABORATORY	0	0	0.0000		0	60. 01
65. 00   06500   RESPI RATORY THERAPY	69, 948			· · · · · ·		65.00
66. 00   06600   PHYSI CAL THERAPY	78, 167					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	7, 496	•				67.00
68. 00 06800 SPEECH PATHOLOGY	7, 644	•				68. 00
69. 00 06900 ELECTROCARDI OLOGY	6, 031	4, 150, 887				1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	57, 992					1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	185, 286			· · · · · ·		1
73.00 07300 DRUGS CHARGED TO PATIENTS	83, 085			,	1	
76. 00 03950 CARDI AC REHAB	22, 041	492, 509	0. 04475	[2] 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 NEW CASTLE FAMILY & INTERNAL MED	53, 422				0	00.00
88.01 08801 NCFIM- NORTHFIELD PARK	2, 554	730, 683	l .		0	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000		0	89. 00
91. 00   09100   EMERGENCY	505, 299					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	177, 836		l .			
200.00   Total (lines 50 through 199)	2, 893, 440	164, 190, 546	l	21, 870, 792	320, 567	200. 00

Health Financial Systems H	ENRY COUNTY MEM	ORIAL HOSPITA	ΔI	In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.		TS Provi der	CCN: 15-0030	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Pre 5/30/2018 9:1	pared:
			le XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursi ng School	Allied Healt Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   INTENSI VE CARE UNI T 41. 00   04100   SUBPROVI DER -   RF	0		0	0 0	0 0	31.00
41. 00   04100   SUBPROVI DER   - 1 RF   42. 00   04200   SUBPROVI DER   43. 00   04300   NURSERY	0		0	0 0	0	42.00
200.00 Total (lines 30 through 199)	0					200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem	Inpati ent	200.00
cost center bescriptron	Adjustment	(sum of cols		(col. 5 ÷	Program Days	
	Amount (see	1 through 3, minus col. 4		col . 6)	Trogram bays	
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0		0 7, 13			
31.00 03100 INTENSIVE CARE UNIT			0 1, 64			
41. 00   04100   SUBPROVI DER - I RF	0		0	0.00		
42. 00   04200   SUBPROVI DER	0		0	0.00		
43. 00   04300   NURSERY			0 72			
200.00 Total (lines 30 through 199)			0 9, 50	)1	4, 030	200.00
Cost Center Description	Inpatient Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	0.00					

30. 00 31. 00 41. 00 42. 00 43. 00

200.00

30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY

Total (lines 30 through 199)

200.00

 
 Heal th Financial
 Systems
 HENRY COUNTY
 MEMORIAL HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 15-0030
 | Peri od: | Worksheet D | From 01/01/2017 | Part IV | To | 12/31/2017 | Date/Time Prepared: THROUGH COSTS

					5/30/2018 9:13 am	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician		Nursi ng		Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0		0	0	50.00
52.00  05200   DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
57. 00  05700 CT SCAN	0	0		0	0	57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00   06000   LABORATORY	0	0		0 0	0	60.00
60. 01   06001   BL00D   LABORATORY	0	0		0 0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0		0 0	0	73.00
76. 00   03950   CARDI AC REHAB	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 NEW CASTLE FAMILY & INTERNAL MED	0	0		0 0	0	88. 00
88.01 08801 NCFIM- NORTHFIELD PARK	0	0		0 0	0	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89. 00
91. 00   09100   EMERGENCY	0	0		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00
			•	*		

THROUGH COSTS

Title XVIII				'	0 12/31/2017	5/30/2018 9: 1	3 am
Medical Education Cost   Cos			Title	XVIII			
Education   Cost   Co	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
Cost   4)   Col. 2, 3 and   Col. 8)   Col. 7)   Col. 2, 20   Col.		Medi cal	(sum of col 1	Outpati ent	(from Wkst.	to Charges	
ANCILLARY SERVICE COST CENTERS		Educati on	through col.	Cost (sum of		(col. 5 ÷	
ANCI LLARY SERVI CE COST CENTERS   S. 00   S		Cost	4)	col. 2, 3 and	col. 8)	col. 7)	
ANCI LLARY SERVICE COST CENTERS				- /			
50.00		4. 00	5. 00	6. 00	7. 00	8. 00	
52. 00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   1, 612, 839   0.000000   52. 00   54. 00   05400   RADI OLOGY-DI AGNOSTI C   0   0   0   0   16, 277, 792   0.000000   54. 00   57. 00   05700   CT SCAN   0   0   0   0   21, 219, 040   0.000000   54. 00   58. 00   05800   MAGNETI C RESONANCE IMAGING (MRI )   0   0   0   0   6, 122, 080   0.000000   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0.000000   60. 00   06000   LABORATORY   0   0   0   0   0   0.000000   65. 00   06001   BLOOD LABORATORY   0   0   0   0   0   0   0.000000   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   5, 418, 729   0.000000   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   3, 869, 538   0.000000   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   3, 869, 538   0.000000   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   134, 415   0.000000   66. 00   06600   PHYSI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   134, 415   0.000000   67. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   18, 233, 618   0.000000   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   18, 233, 618   0.000000   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   18, 330, 933   0.000000   74. 00   07400   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   3, 138, 758   0.000000   75. 00   07500   LABORATORY   0   0   0   0   0   0   0.000000   75. 00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   75. 00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   75. 00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   75. 00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   75. 00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   75. 00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0   75. 00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0		_	_	1 -			
54. 00		0	0		· · ·		
57. 00   05700   CT SCAN   0   0   0   0   21, 219, 040   0.000000   57. 00   58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI ) 0   0   0   6, 122, 080   0.000000   58. 00   0.000000   59. 00   0.000000   59. 00   0.000000   59. 00   0.000000   59. 00   0.000000   60. 00   0.0000000   60. 00   0.000000   60. 00   0.000000   60. 00   0.000000		0	0		· · ·		•
58. 00         05800         MAGNETI C RESONANCE IMAGING (MRI)         0         0         6, 122, 080         0.000000         58. 00           59. 00         05900         CARDIAC CATHETERI ZATI ON         0         0         0         0.000000         59. 00           60. 00         06000         LABORATORY         0         0         0         24, 967, 939         0.000000         60. 00           60. 01         06001         BLOOD LABORATORY         0         0         0         0.000000         60. 00           65. 00         06500         RESPI RATORY THERAPY         0         0         5, 418, 729         0.000000         65. 00           66. 00         06600         PHYSI CAL THERAPY         0         0         0         3, 869, 538         0.000000         65. 00           67. 00         06700         OCCUPATI ONAL THERAPY         0         0         360, 914         0.000000         67. 00           68. 00         O6800         SPEECH PATHOLOGY         0         0         134, 415         0.000000         68. 00           69. 00         O6900         ELECTROCARDI OLOGY         0         0         4, 150, 887         0.000000         71. 00           71. 00         O		0	0	C			
59. 00         05900         CARDI AC CATHETERI ZATI ON         0         0         0         0         0.000000         59. 00           60. 00         060000         LABORATORY         0         0         0         24, 967, 939         0.000000         60. 00           60. 01         06001         BLOOD LABORATORY         0         0         0         0         0.000000         60. 01           65. 00         06500         RESPI RATORY THERAPY         0         0         0         5, 418, 729         0.000000         65. 00           66. 00         06600         PHYSI CAL THERAPY         0         0         0         3, 869, 538         0.000000         65. 00           67. 00         06700         OCCUPATI ONAL THERAPY         0         0         0         360, 914         0.000000         66. 00           67. 00         06700         OCCUPATI ONAL THERAPY         0         0         0         360, 914         0.000000         67. 00           68. 00         06800         SPEECH PATHOLOGY         0         0         0         134, 415         0.000000         67. 00           71. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0		0	0	C	· · ·		•
60. 00		0	0	C	6, 122, 080		
60. 01		0	0	C	0		
65. 00		0	0	C	24, 967, 939		
66. 00		0	0	C	0		
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 360, 914 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 134, 415 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 4, 150, 887 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 10, 330, 226 0.000000 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 18, 233, 618 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 8, 340, 933 0.000000 73. 00 76. 00 0 9500 CARDI AC REHAB 0 0 0 0 492, 509 0.000000 76. 00 000000 0000000 000000 000000 000000		0	0	C			
68. 00   06800   SPEECH PATHOLOGY   0   0   0   134, 415   0.000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   4, 150, 887   0.000000   69. 00   071. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0   18, 233, 618   0.000000   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   18, 233, 618   0.000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   8, 340, 933   0.000000   73. 00   76. 00   000000   74. 00   75.		0	0	C	· · ·		1
69. 00   06900   ELECTROCARDI OLOGY   0   0   0   4, 150, 887   0.000000   69. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   10, 330, 226   0.000000   71. 00   72. 00   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 00   73. 00   74		0	0	C	· ·		
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   10, 330, 226   0.000000   71. 00   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 00   73. 00   74. 00   73. 00   74. 0		0	0	C	· ·		
72. 00   07200   1MPL. DEV. CHARGED TO PATIENT   0   0   0   18, 233, 618   0.000000   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 00   0   0   0   0   0   0   0   0   0		0	0	C			•
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   8,340,933   0.000000   73. 00   76. 00   0   0   0   0   0   0   0   0   0		0	0	C	· · ·		
76. 00 03950 CARDI AC REHAB 0 0 0 492, 509 0.000000 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	C	· · ·		1
SECTION   SERVICE COST CENTERS   SECTION   S		0	0	C	· · ·		
88. 00   08800   NEW CASTLE FAMILY & INTERNAL MED   0   0   3,138,758   0.000000   88. 00   88. 01   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   16,116,656   0.000000   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   1,270,281   0.000000   92. 00   09200   08500   09200   08500   092		0	0	C	492, 509	0.000000	76. 00
88. 01   08801   NCFIM- NORTHFIELD PARK   0   0   0   730, 683   0.000000   88. 01   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0.000000   89. 00   91. 00   09100   EMERGENCY   0   0   0   16, 116, 656   0.000000   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   0   1, 270, 281   0.000000   92. 00   0   0   0   0   0   0   0   0   0							
89. 00     08900     FEDERALLY QUALIFIED HEALTH CENTER     0     0     0     0     0.000000     89. 00       91. 00     09100     EMERGENCY     0     0     0     16, 116, 656     0.000000     91. 00       92. 00     09200     OBSERVATION BEDS (NON-DISTINCT PART)     0     0     0     1, 270, 281     0.000000     92. 00		0	0	C			
91. 00   09100   EMERGENCY   0   0   16, 116, 656   0. 000000   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   1, 270, 281   0. 000000   92. 00		0	0	C	730, 683		
92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   1, 270, 281   0. 000000   92. 00		0	0	C	0		1
		0	0	C			
200.00   Total (lines 50 through 199)   0  0  0  164,190,546   200.00		0	0	C	· · ·		1
	200.00   Total (lines 50 through 199)	0	0	C	164, 190, 546		200. 00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-0030	Peri od: Worksheet D			
THROUGH COSTS		From 01/01/2017   Part IV			

THROUGH COSTS				rom 01/01/2017 o 12/31/2017		narad.
			T	0 12/31/2017	Date/Time Pre 5/30/2018 9:1	
		Title XVIII		Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
•	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	Ü	Costs (col. 8	Ü	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0. 000000	2, 673, 979	0	4, 010, 372	0	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	4, 170	0	1, 205	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	1, 067, 351	0	4, 678, 665	0	54.00
57. 00   05700   CT   SCAN	0. 000000	1, 012, 336	0	5, 964, 144	0	57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	122, 614	0	1, 783, 155	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	0	0	0	59.00
60. 00   06000   LABORATORY	0. 000000	2, 845, 600	0	1, 859, 867	0	60.00
60. 01   06001   BLOOD LABORATORY	0. 000000	0	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000	1, 817, 164	0	248, 116	0	65.00
66. 00   06600 PHYSI CAL THERAPY	0. 000000	259, 082	0	6, 926	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	278	0	1, 286	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	20, 925	0	669	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	815, 539	0	1, 744, 847	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 923, 867	0	1, 645, 084	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	5, 932, 243	0	1, 704, 775	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 751, 778	0	2, 097, 935	0	73.00
76. 00   03950   CARDI AC   REHAB	0. 000000	0	0	198, 994	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 NEW CASTLE FAMILY & INTERNAL MED	0. 000000	0	0	0	0	88. 00
88.01 08801 NCFIM- NORTHFIELD PARK	0. 000000	0	0	0	0	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0	0	89. 00
91. 00 09100 EMERGENCY	0. 000000	541, 911	0	3, 446, 184	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	81, 955	0	493, 748	0	92.00
200.00 Total (lines 50 through 199)		21, 870, 792	0	29, 885, 972	0	200.00
		'				

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0030 Peri od: Worksheet D From 01/01/2017 Part V 12/31/2017 Date/Time Prepared: 5/30/2018 9:13 am Title XVIII Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 010, 372 0. 318022 1, 275, 387 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 1, 205 52.00 0.196522 52.00 237 4, 678, 665 05400 RADI OLOGY-DI AGNOSTI C 1, 155, 256 54.00 0. 246920 54.00 57.00 05700 CT SCAN 0.029200 5, 964, 144 0 0 174, 153 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.063746 1, 783, 155 0 0 113, 669 58.00 0 0 59 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59 00 Ω 0 0 60.00 06000 LABORATORY 0. 245987 1, 859, 867 457, 503 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 0 60.01 0 0 06500 RESPIRATORY THERAPY 0. 162553 248, 116 40, 332 65.00 65.00 06600 PHYSI CAL THERAPY 0. 680976 0 6, 926 4, 716 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.790465 1, 286 0 1,017 67.00 06800 SPEECH PATHOLOGY 0 o 68.00 0.823390 669 551 68.00 0 06900 ELECTROCARDI OLOGY 0.091835 0 160, 238 69 00 1 744 847 69 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.182911 1, 645, 084 0 300, 904 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 334782 1, 704, 775 0 0 570, 728 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.437869 2,097,935 0 3,774 918, 621 73.00 03950 CARDI AC REHAB 198, 994 0 76.00 0.662321 131, 798 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 NEW CASTLE FAMILY & INTERNAL MED 0.000000 88.00 0 88. 01 08801 NCFIM- NORTHFIELD PARK 0.000000 0 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89 00 89 00 0 91.00 09100 EMERGENCY 0. 421258 3, 446, 184 0 0 1, 451, 733 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.972997 493, 748 0 480, 415 92.00 7, 237, 258 200. 00 200.00 Subtotal (see instructions) 0 29, 885, 972 3.774 Less PBP Clinic Lab. Services-Program 0 201.00 201. 00 Only Charges

29, 885, 972

0

3, 774

7, 237, 258 202. 00

202.00

Net Charges (line 200 - line 201)

				10 12/31/2017	Date/IIme Prep   5/30/2018 9:13	
		Title	XVIII	Hospi tal	PPS	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0	0				50.00
52.00   05200   DELI VERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57. 00   05700   CT   SCAN	0	0				57.00
58.00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00   06000   LABORATORY	0	0				60.00
60. 01   06001   BLOOD   LABORATORY	0	0				60.01
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 653	1			73.00
76. 00 03950 CARDI AC REHAB	0	0				76.00
OUTPATIENT SERVICE COST CENTERS			I			88. 00
88.00   08800   NEW CASTLE FAMILY & INTERNAL MED 88.01   08801   NCFIM- NORTHFIELD PARK	0	0				88. 00
88.01   08801   NCFIM- NORTHFIELD PARK 89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
	0	0				91.00
91.00   09100   EMERGENCY 92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		0				91.00
	0	1 (5)				92.00 200.00
		1, 653				200. 00 201. 00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	١				2	201.00
202.00 Net Charges (line 200 - line 201)		1, 653			,	202.00
202.00   Net Glarges (Title 200 - Title 201)	١	1, 003	I		2	.02.00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL In Lieu o					
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0030	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre 5/30/2018 9:1	pared:		
	Title XVIII	Hospi tal	PPS			
Cost Center Description						
			1. 00			
PART I - ALL PROVIDER COMPONENTS						

	Title XVIII Hospital	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7, 136	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7, 136	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
4. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation bed days)	6, 212	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0, 212	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
7 00	reporting period (if calendar year, enter 0 on this line)	0	7.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	3, 056	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	O	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
40.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	9, 545, 371	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18)   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
2 00	7 x line 19)	· ·	21.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
26. 00	x line 20) Total swing-bed cost (see instructions)	0	26. 00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9, 545, 371	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	1,010,01	
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29.00	Pri vate room charges (excluding swing-bed charges)	0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges)   General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	30. 00 31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00000	
33. 00	Average semi-private room per diem charge (line 4)	0. 00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0 545 271	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9, 545, 371	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 337. 64	
39.00	Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)	4, 087, 828 0	39. 00 40. 00
40. 00 41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	4, 087, 828	
	1 10 0	., 50., 520	

COMPUT	Financial Systems HE ATION OF INPATIENT OPERATING COST	NRY COUNTY MEM	Provi der C	CN: 15-0030	Peri od:	u of Form CMS-2 Worksheet D-1		
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 9:1		
			Title	XVIII	Hospi tal	PPS	o am	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1. 00	2. 00	3. 00	4. 00	5. 00		
42.00	NURSERY (title V & XIX only)	0	0	0.0	0 0	0	42.00	
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	3, 274, 738	1, 645	1, 990. 7	2 974	1, 938, 961	43.00	
44. 00		3, 274, 730	1, 043	1, 990. 7	2 774	1, 730, 701	44.00	
45. 00	BURN INTENSIVE CARE UNIT						45. 00	
	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
	Cost Center Description							
10.00	Danner i meti ont encillent encillent encil	-+ D 21 1	2 11 == 200)			1. 00	40.00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			one)		6, 267, 375 12, 294, 164		
49.00	PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see mstructi	JIIS)		12, 294, 104	49.00	
50. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst D sur	of Parts L and	881, 166	50.00	
00.00		211 0111 1 0 0 11110	00. 1. 000 (1. 0		. or ranto rant	1	00.00	
51.00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	320, 567	51.00	
	and IV)							
52.00	Total Program excludable cost (sum of lines	,				1, 201, 733		
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		erated, non-ph	ysıcıan anesth	netist, and	11, 092, 431	53.00	
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					-	
54.00	Program di scharges					0	54.00	
55.00	Target amount per discharge					- 1	55.00	
56.00	Target amount (line 54 x line 55)					0	56.00	
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (	line 56 minus	line 53)	0	57.00	
58.00	Bonus payment (see instructions)					0		
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	ompounded by the	0.00	59.00	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	nost raport ur	ndated by the	markat haskat		0.00	60.00	
61.00	If line 53/54 is less than the lower of line				the amount by	0.00	1	
01.00	which operating costs (line 53) are less that					١	01.00	
	amount (line 56), otherwise enter zero (see				3			
	Relief payment (see instructions)					0		
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63.00	
44.00	PROGRAM INPATIENT ROUTINE SWING BED COST  00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See							
64. 00	instructions)(title XVIII only)	is infough bece	elliber 31 of th	e cost reporti	ng perrou (see	0	64.00	
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reporting	period (See	o	65.00	
	instructions)(title XVIII only)				, , , , , , , , , , , , , , , , , , , ,			
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66.00	
<b>47.00</b>	CAH (see instructions)		D	6 11			/7.00	
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	n December 31	or the cost re	eporting period	0	67.00	
68 00	Title V or XIX swing-bed NF inpatient routing	e costs after [	December 31 of	the cost repo	orting period	0	68.00	
00.00	(line 13 x line 20)	2 00010 41101 2		т.ю обот горо	or tring por rod		00.00	
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (	(line 67 + lin	e 68)		0	69.00	
	PART III - SKILLED NURSING FACILITY, OTHER NU						ļ	
70.00	Skilled nursing facility/other nursing facil	-		• •	)		70.00	
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ iine	2)			71.00	
73. 00	Medically necessary private room cost applications		m (line 14 x l	ine 35)			73.00	
74. 00	Total Program general inpatient routine serv						74.00	
75.00	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B, F	Part II, column		75.00	
	26, line 45)							
76.00	Per diem capital related costs (line 75 ÷ li						76.00	
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus					 	77. 00 78. 00	
79. 00	Aggregate charges to beneficiaries for excess	,	provider recor	ds)			79.0	
80.00	00 0	,		*.	nus line 79)		80.0	
81. 00	Inpatient routine service cost per diem limi				<b>,</b>		81.0	
82.00	Inpatient routine service cost limitation (						82.00	
83.00	Reasonable inpatient routine service costs (		ns)				83.0	
84.00	Program inpatient ancillary services (see in:		anc)				84.0	
85.00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•	•			 	85. 00 86. 00	
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS		ii ougiT oo)				1 00.00	
	OGMI GITTI ON OF ODSERVATION DED TASS						4	
87. 00	Total observation bed days (see instructions	)				924	87.00	
87. 00 88. 00	,		: line 2)			924 1, 337. 64		

Health Financial Systems HE	ENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 9:1	pared: 3 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 373, 419	9, 545, 371	0. 14388	3 1, 235, 979	177, 836	90.00
91.00 Nursing School cost	0	9, 545, 371	0.00000	0 1, 235, 979	0	91.00
92.00 Allied health cost	0	9, 545, 371	0.00000	0 1, 235, 979	0	92.00
93.00 All other Medical Education	0	9, 545, 371	0. 00000	0 1, 235, 979	0	93. 00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0030	Peri od: From 01/01/2017	Worksheet D-1	
		To 12/31/2017	Date/Time Pre 5/30/2018 9:1	pared: 3 am
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				
1.00 Inpatient days (including private room	days and swing-bed days, excluding newborn)		7, 136	1.00
2 00 Innetient days (including private room	days avaluating aging had and nawharn days)		7 10/	2 00

	Cost Contar Description	LOST	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7, 136	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7, 136	
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	6, 212	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0,2.2	5.00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)	0	7.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	97	9. 00
10.00	newborn days)	0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12 00	through December 31 of the cost reporting period	0	12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	720	15.00
16.00	Nursery days (title V or XIX only)	34	16. 00
47.00	SWI NG BED ADJUSTMENT	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0. 00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18.00
	reporting period		
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
20. 00	reporting period	0.00	20.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	9, 545, 371	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
2 00	7 x line 19)	ū	200
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
0/ 00	x line 20)		0, 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 9, 545, 371	
27.00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT	7, 343, 371	27.00
28. 00		0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	29. 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 33. 00	Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)	0.00	1
36.00	Private room cost differential adjustment (line 3 x line 35)	0	
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	9, 545, 371	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		-
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 337. 64	38.00
	Program general inpatient routine service cost (line 9 x line 38)	129, 751	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	129, 751	41.00

5.00	lotal swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
/ 00	reporting period	0	/ 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	U	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	O	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	97	9. 00
7. 00	newborn days)	,,	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	<u> </u>	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)		15.00
16.00	Nursery days (title V or XIX only)	34	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18.00
	reporting period		
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19.00
	reporting period	0.00	
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
21 00	reporting period	0 545 071	21 00
21. 00	Total general inpatient routine service cost (see instructions)	9, 545, 371	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	. 0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
23.00	x line 18	·	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	O	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
20.00	x line 20)	o o	20.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9, 545, 371	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	1,010,01	
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	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 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	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 and private room cost differential (line	9, 545, 371	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 337. 64	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	129, 751	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	129, 751	41.00

	Financial Systems HE FATION OF INPATIENT OPERATING COST	NRY COUNTY MEMO	Provi der C	CN: 15-0030	Peri od:	u of Form CMS-2 Worksheet D-1		
					From 01/01/2017 To 12/31/2017	Date/Time Pre		
	·		Ti tl	e XIX	Hospi tal	5/30/2018 9:1 Cost	3 am	
	Cost Center Description	Total Inpatient Cost 1.00	Total Inpati ent Days 2.00	Average Per Diem (col. 1 ÷ col. 2) 3.00	Program Days	Program Cost (col. 3 x col. 4) 5.00		
42. 00	NURSERY (title V & XIX only)	1, 314, 755	720				42.00	
	Intensive Care Type Inpatient Hospital Units							
	CORONARY CARE UNIT	3, 274, 738	1, 645	1, 990. 7	2 6	11, 944	43. 00 44. 00 45. 00 46. 00 47. 00	
	cost center bescription					1. 00		
48. 00	Program inpatient ancillary service cost (Wk					79, 136		
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instructi	ons)		282, 917	49.00	
50. 00		atient routine	servi ces (fro	m Wkst. D, sur	n of Parts I and	0	50.00	
51. 00			•			0	51.00	
	and IV)		`			_		
52. 00 53. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost excludemedical education costs (line 49 minus line!	ding capital re	elated, non-ph	ysician anesth	netist, and	0	52.00 53.00	
	TARGET AMOUNT AND LIMIT COMPUTATION	,						
54. 00 55. 00	Program discharges Target amount per discharge					-	54.00 55.00	
56. 00						0.00	l .	
57. 00	Difference between adjusted inpatient operati	ing cost and ta	irget amount (	ine 56 minus	line 53)	0	57.00	
58.00	1	norting ported	anding 100/	undated and a	ampaundad by +ba	0 00	58.00	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	ending 1996, 1	updated and co	ompounaea by the	0.00	59.00	
60.00	Lesser of lines 53/54 or 55 from prior year					0. 00	60.00	
61.00	00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							
62.00	Relief payment (see instructions)							
63.00	ON Allowable Inpatient cost plus incentive payment (see instructions)							
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See							
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the (	cost reportino	g period (See	0	65.00	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66.00	
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost re	eporting period	0	67.00	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00	
69. 00	Total title V or XIX swing-bed NF inpatient   PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00	
70.00	Skilled nursing facility/other nursing facili	ity/ICF/IID rou	ıtine service (	cost (line 37)	)		70.00	
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		ine /0 ÷ line	2)			71.00	
73.00	Medically necessary private room cost applications		n (line 14 x li	ne 35)			73.00	
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient	•			Part II, column		74.00 75.00	
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.00	
77.00	•	,					77.00	
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78.00	
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			*.	nus line 70)		79.00	
81. 00	Inpatient routine service costs for compa		ost rimitatiUI	. (11/16 /0 11111	143 TTHE 17)		81.0	
82.00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .				82.00	
83. 00 84. 00	Reasonable inpatient routine service costs (		ıs)				83.00	
85.00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ons)				85.0	
86.00	Total Program inpatient operating costs (sum	of lines 83 th					86.00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					024	07 0	
	Total observation bed days (see instructions)	•				924		
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	·line 2)		I	1, 337. 64	88.00	

Health Financial Systems HE	ENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 9:1	pared: 3 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 373, 419	9, 545, 371	0. 14388	3 1, 235, 979	177, 836	90.00
91.00 Nursing School cost	0	9, 545, 371	0.00000	0 1, 235, 979	0	91.00
92.00 Allied health cost	0	9, 545, 371	0. 00000	0 1, 235, 979	0	92.00
93.00 All other Medical Education	0	9, 545, 371	0. 00000	0 1, 235, 979	0	93.00

Heal th	Financial Systems HENRY CO	DUNTY MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 9:1	pared: 3 am
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS					
	D3000 ADULTS & PEDIATRICS			4, 212, 913		30.00
	03100 INTENSIVE CARE UNIT			2, 615, 793		31.00
	04100 SUBPROVI DER – I RF			0		41.00
	04200 SUBPROVI DER			0		42.00
	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS			0 (70 070	252.224	
	OSOOO OPERATING ROOM		0. 31802	· · ·		
	D5200 DELIVERY ROOM & LABOR ROOM		0. 19652			1
	D5400 RADI OLOGY-DI AGNOSTI C		0. 24692	· · ·	263, 550	
	D5700 CT SCAN		0. 02920			1
	D5800 MAGNETIC RESONANCE IMAGING (MRI)		0.06374			
	D5900 CARDI AC CATHETERI ZATI ON		0.00000		700 240	59.00
	06000 LABORATORY		0. 24607		700, 240	1
	D6001 BL00D_LABORATORY D6500 RESPI RATORY_THERAPY		0. 00000 0. 16255		205 205	1
	06600 PHYSI CAL THERAPY		0. 16255			
	D6700 OCCUPATI ONAL THERAPY		0. 68097		•	1
	06800 SPEECH PATHOLOGY		0. 79040			
	06900 SPEECH PATHOLOGY		0. 62339			
	D7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 09163			1
	07200 IMPL. DEV. CHARGED TO PATTENTS		0. 18291			
	07300 DRUGS CHARGED TO PATIENTS		0. 33476			
	03950 CARDIAC REHAB		0. 43780		1, 204, 910	76.00
	OUTPATIENT SERVICE COST CENTERS		0.00232	0	0	, 0.00
	D8800 NEW CASTLE FAMILY & INTERNAL MED		0.00000		0	88.00
	DOOOD NEW CASTLE FAMILET & THIERWAL MED		0.00000		0	

0.000000

0. 000000

0. 421258

0. 972997

541, 911

21, 870, 792

21, 870, 792

81, 955

0 88.01

0

6, 267, 375 200. 00

228, 284

79, 742

89.00

91.00

92.00

201. 00 202. 00

88. 01 08801 NCFIM- NORTHFIELD PARK

91. 00 09100 EMERGENCY

200. 00 201. 00

202.00

89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER

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 HENRY COUNTY	MEMORIAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 9:1	
	Ti tI	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati 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			167, 503		30.00
31.00 03100 INTENSIVE CARE UNIT			40, 218		31.00
41. 00   04100   SUBPROVI DER - I RF			0		41.00
42. 00  04200  SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00   05000   OPERATING ROOM		0. 31802		15, 992	50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 19652		0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 24692		2, 414	54.00
57. 00  05700   CT   SCAN		0. 02920		408	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.06374		182	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 00000		0	59.00
60. 00   06000   LABORATORY		0. 24598		13, 747	60.00
60. 01   06001   BL00D   LABORATORY		0. 00000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY		0. 16255		5, 663	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 68097		1, 583	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 79046		0	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 82339		0	68.00
69. 00   06900   ELECTROCARDI OLOGY		0. 09183		526	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 18291	1 74, 825	13, 686	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 33478		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 43786		18, 560	73.00
76. 00 03950 CARDI AC REHAB		0. 66232	21 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 NEW CASTLE FAMILY & INTERNAL MED		1. 93498		0	88. 00
88. 01 08801 NCFIM- NORTHFIELD PARK		0. 36953		0	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	89. 00
91 00 09100 EMERGENCY		∩ 42125	8 15 133	6 375	91 00

0. 421258

0. 972997

15, 133

308, 027

308, 027

91.00

0 92.00

79, 136 200. 00 201. 00 202. 00

6, 375

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	HENRY COUNTY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0030	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 9:13 am

Natl A				10 12/31/2017	5/30/2018 9:1	
NATE A - INPATE INT HOSPITAL SERVICES UNDER IPPS   0   1.00   1			Title XVIII	Hospi tal		<u> </u>
NATE A - INPATE INT HOSPITAL SERVICES UNDER IPPS   0   1.00   1						
1.00   DRG Amounts other than outlier Payments for discharges occurring prior to October 1 (see   6.099, 629   1.01   1.02   1.02   1.02   1.02   1.03   1.02   1.03   1					1. 00	
1.01   DRG amounts other than outlier payments for discharges occurring prior to October 1 (see   0.099,629   1.01   Instructions)   2,480,634   1.02   1.03   1.02   1.03   1.	1 00					1 00
1.02   Instructions   1.03   Instructions   1.02   Instructions   1.03   Instructions		DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 (	(see	- 1	1.00
1.03   DRS for Federal Specific Operating payment for Model 4 BPCI for discharges occurring prior to October 1	1. 02	DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	2, 480, 634	1. 02
DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after   0   1.04	1. 03	DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	prior to October	0	1.03
2.00         Outli er payments for discharges (see instructions)         539         2.00           2.01         Outli er perconcil list ion amount         0         2.01           3.00         Managed Care Simul atted Payments         0         2.01           4.00         Bed days avail able divided by number of days in the cost reporting period (see instructions)         45.47         4           5.00         Bod days avail able divided by number of days in the cost reporting period ending of or before 12/3/1/96, (see instructions)         5.00           6.00         File Count for all logation and section of the cost reporting period ending of or before 12/3/1/96, (see instructions)         5.00           7.00         MM Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1)         0.00         7.00           7.01         AGA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report stradied by July 1, 2011 see instructions.         6.00         8.00           8.00         Adjustment (increase or decrease) to the FIE count for all opathic and ostoopathic programs and conditions and ostoopathic programs and conditions and ostoopathic programs.         0.00         8.00           8.01         The amount of increase if the hospital was awarded FIE cap slots under \$ 5503 of the ACA. If the cost report stradie is July 1, 2011, see instructions and cost pathic and steep slots and and accompany and and programs.         0.00	1. 04	DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	on or after	0	1. 04
2.02   2.02   2.02   3.00		Outlier payments for discharges. (see instructions)			539	2.00
Managed Car's Simulated Payments			ions)		0	l
Bed days available divided by number of days in the cost reporting period (see instructions)   4.0			10113)		0	1
FIE count for all logathic and osteopathic programs for the most recent cost reporting period ending of or before 12/31/1996, (see instructions)   0.00		Bed days available divided by number of days in the cost repo	rting period (see instru	uctions)	45. 47	•
FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00	5. 00	FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending on	0. 00	5.00
7.00         MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(B)(2) if the cost report straddies July 1, 2011 then see instructions.         0.00         7.00           8.00         Adjustment (Increase or decrease) to the FTE count for all lopathic and osteopathic) programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50009 (August 1, 2002).         0.00         8.00           8.01         The amount of increase if the hospital was awarded FTE cap slots under \$5503 of the ACA. If the cost report straddies July 1, 2011, see instructions.         0.00         8.02           8.02         The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$5504 of ACA. (see instructions)         0.00         8.02           9.00         Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see Instructions)         0.00         10.00           10.00         FTE count for allopathic and osteopathic programs in the current year from your records         0.00         10.00           10.00         FTE count for residents in dental and podiatric programs.         0.00         10.00           10.00         Total allowable FTE count for the prior year.         0.00         10.00           10.00         Total allowable FTE count for the prior year.         0.00         10.00           10.00         Adjustment for residents displaced by program or	6. 00	FTE count for allopathic and osteopathic programs which meet	the criteria for an add-	on to the cap	0. 00	6.00
cost report straddles July 1, 2011 then see instructions. 8. 00. Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under § 5500 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) 9. 00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions) 9. 01 TE count for allopathic and osteopathic programs in the current year from your records 9. 02 TE count for allopathic and osteopathic programs. 9. 03 Current year allowable FTE (see instructions) 9. 04 Current year allowable FTE count for the prior year. 9. 05 Total allowable FTE count for the prior year. 9. 06 Total allowable FTE count for the prior year. 9. 07 Total allowable FTE count for the prior year. 9. 08 Sum of lines 2 through 14 divided by 3. 9. 09 Total allowable FTE count for the penul timate year lift that year ended on or after September 30, 1997, otherwise enter zero. 9. 00 Sum of lines 12 through 14 divided by 3. 9. 00 Sum of lines 12 through 14 divided by 1. 9. 00 Sum of lines 2 through 14 divided by 1. 9. 00 Sum of lines 2 through 14 divided by 1. 9. 00 Current year residents displaced by program or hospital closure 9. 0. 00 Increase enter zero. 9. 0. 01 Total years of lines 19 or 20 (see instructions) 9. 0. 02 Current year residents of prior year residents displaced by program or hospital closure 9. 0. 02 Sum of lines 2 through 14 divided by 1. 9. 0. 02 Sum of lines 2 through 14 divided by 1. 9. 0. 02 Sum of lines 2 through 14 divided by 1. 9. 0. 02 Sum of lines 2 through 14 divided by 1. 9. 0. 02 Sum of lines 2 through 14 divided	7. 00		under 42 CFR §412.105(f)	(1) (i v) (B) (1)	0. 00	7. 00
affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 2634Ö (May 12, 1998), and 67 FR 50069 (August 1, 2002).  8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)  9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)  10.00 FTE count for all opathic and osteopathic programs in the current year from your records  10.00 FTE count for all opathic and osteopathic programs in the current year from your records  10.00 Current year allowable FTE (see instructions)  10.00 Total allowable FTE count for the prior year.  10.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 16.00 Adjustment for residents in initial years of the program or hospital closure  10.00 Sum of lines 12 through 14 divided by 3.  10.00 Sum of lines 12 through 14 divided by 10 10 10 10 10 10 10 10 10 10 10 10 10	7. 01		42 CFR §412.105(f)(1)(i	v)(B)(2) If the	0. 00	7. 01
8.01   The amount of increase   if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradide s July 1, 2011, see instructions.  The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)  9.00   Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)  10.00   FTE count for allopathic and osteopathic programs in the current year from your records  10.00   FTE count for allopathic and osteopathic programs in the current year from your records  10.00   FTE count for residents in dental and podiatric programs.  10.00   FTE count for residents in dental and podiatric programs.  10.00   FTE count for residents in dental and podiatric programs.  10.00   FTE count for residents in the prior year.  10.00   FTE count for residents in for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.  10.00   FTE count for residents in initial years of the program	8. 00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.			0. 00	8. 00
The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap sl	ots under § 5503 of the	ACA. If the cost	0. 00	8. 01
9.00   Sum of   lines 5   plus 6   minus   lines (7 and 7.01)   plus/minus   lines (8, 8,01 and 8,02) (see   0.00   9.00   9.00   10.00   FTE count for all opathic and osteopathic programs in the current year from your records   0.00   10.00   11.00   TEC count for residents in dental and podiatric programs.   0.00   12.00   12.00   13.00   10.01   10.00   13.00   10.00   13.00   10.00   13.00   10.00   13.00   10.00   13.00   10.00   13.00   10.00   13.00   10.00   13.00   10.00   13.00   10.00   14.00   10.00   10.00   14.00   14.00   10.00   10.00   10.00   14.00   14.00   16.00	8. 02	The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teachi	ng hospital	0. 00	8. 02
10.00   FTE count for all opathic and osteopathic programs in the current year from your records   10.00   10.00   11.00   TEC count for residents in dental and podiatric programs.   0.00   11.00   12.00   12.00   13.00   13.00   14.00   13.00   14.00   14.00   15.00   14.00   15.00   14.00   15.00	9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin	es (8, 8,01 and 8,02)	(see	0. 00	9. 00
12.00   Current year allowable FTE (see instructions)   0.00   12.00   13.00		FTE count for allopathic and osteopathic programs in the curr	ent year from your recor	-ds		•
13.00   Total all owable FTE count for the prior year.   0.00   13.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.0						
14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.   15.00   Sum of lines 12 through 14 divided by 3.   0.00   15.00   16.00   Adjustment for residents in initial years of the program   0.00   15.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   18.00   19.0		, , , , , , , , , , , , , , , , , , ,				1
15.00   Sum of lines 12 through 14 divided by 3.   0.00   15.00   16		Total allowable FTE count for the penultimate year if that ye	ar ended on or after Sep	otember 30, 1997,		1
16.00       Adjustment for residents in initial years of the program       0.00       16.00         17.00       Adjustment for residents displaced by program or hospital closure       0.00       17.00         18.00       Adjusted rolling average FTE count       0.00       17.00         19.00       Current year resident to bed ratio (see instructions)       0.000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000       20.00         21.00       Inter the lesser of lines 19 or 20 (see instructions)       0.000000       20.00         22.01       IME payment adjustment (see instructions)       0.000000       22.00         1 IME payment adjustment - Managed Care (see instructions)       0.000000       22.00         22.01       IME payment adjustment - Managed Care (see instructions)       0.00       22.00         24.00       IME payment adjustment of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105       0.00       23.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment factor. (see instructions)       0.000000       26.00 <td>15. 00</td> <td></td> <td></td> <td></td> <td>0. 00</td> <td>15.00</td>	15. 00				0. 00	15.00
18. 00       Adjusted rolling average FTE count       0.00       18.00         19. 00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       19.00         20. 00       Prior year resident to bed ratio (see instructions)       0.000000       20.00         21. 00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22. 01       IME payment adjustment (see instructions)       0.22.00         1IME payment adjustment - Managed Care (see instructions)       0.00       22.01         1Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA       0.00       23.00         23. 00       (f)(1)(iv)(c).       0.00       24.00         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 -0-, then enter the lower of line 23 or line 24 (see instructions)       0.00       25.00         26. 00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00       27.00         27. 00       IME payments adjustment factor. (see instructions)       0.000000       27.00         28. 01       IME add-on adjustment amount - Managed Care (see instructions)       0.000000       27.00         29. 00       Total IME payment (sum of lines						1
19.00   Current year resident to bed ratio (line 18 divided by line 4).   0.000000   19.00   20.00   Prior year resident to bed ratio (see instructions)   0.000000   20.00   20.00   20.00   20.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   20.	17.00	Adjustment for residents displaced by program or hospital clo	sure		0.00	17.00
20.00	18.00	Adjusted rolling average FTE count			0. 00	18. 00
21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   21.00     22.00   IME payment adjustment (see instructions)   0   22.00     1 IME payment adjustment - Managed Care (see instructions)   0   22.00     1 IME payment adjustment - Managed Care (see instructions)   0   22.01     1 IME payment adjustment for the Add-on for § 422 of the MMA     23.00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00     (f)(1)(iv)(C)			.).			
22.00 IME payment adjustment (see instructions)  1 IME payment adjustment - Managed Care (see instructions)  1 IME payment adjustment - Managed Care (see instructions)  2 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  2 IME Payment adjustment of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  2 IME FTE Resident Count Over Cap (see instructions)  2 IME FTE Resident Count Over Cap (see instructions)  3 IME FTE Resident Count Over Cap (see instructions)  4 IME FTE Resident Count Over Cap (see instructions)  5 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see on the count of line 24 (see on the count of line 25 by line 4)  6 IME payments adjustment factor. (see instructions)  7 IME payments adjustment factor. (see instructions)  8 IME payments adjustment amount (see instructions)  9 IME add-on adjustment amount (see instructions)  10 IME add-on adjustment amount - Managed Care (see instructions)  10 IME payment (sum of lines 22 and 28)  11 IME payment - Managed Care (sum of lines 22.01 and 28.01)  12 IME payment - Managed Care (sum of lines 22.01 and 28.01)  13 Ime payment - Managed Care (sum of lines 22.01 and 28.01)  14 IME payment - Managed Care (sum of lines 22.01 and 28.01)  15 Ime add-on adjustment amount (see instructions)  16 Ime payment (sum of lines 22.01 and 28.01)  17 Ime payment (sum of lines 22.01 and 28.01)  18 Ime payment (sum of lines 22.01 and 28.01)  29 Ime payment (sum of lines of lines 22.01 and 28.01)  29 Ime payment of lines						
22. 01   IME payment adjustment - Managed Care (see instructions)   10   10   10   10   10   10   10   1						
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 (f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.28.01 IME add-on adjustment amount (see instructions) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 IME add-on adjustment (sum of lines 22 and 28) 0.29.01 Total IME payment (sum of lines 22 and 28) 0.29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.38 30.00 31.00 Sum of lines 30 and 31 23.80 32.00 33.00 Allowable disproportionate share percentage (see instructions) 8.85 33.00					-	ł
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	22. 01		0 0 11 1911		0	22.01
24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  8.85 33.00	23. 00	Number of additional allopathic and osteopathic IME FTE resid		CFR 412. 105	0.00	23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  31.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  8.85 33.00	24.00				0.00	24 00
26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment factor. (see instructions)       0.000000       27.00         28.00       IME add-on adjustment amount (see instructions)       0.000000       28.00         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0.000000       28.01         29.00       Total IME payment (sum of lines 22 and 28)       0.000000       29.00         29.01       Disproportionate Share Adjustment       0.000000       29.01         30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       4.38       30.00         31.00       Percentage of Medicaid patient days (see instructions)       19.42       31.00         32.00       Sum of lines 30 and 31       23.80       32.00         33.00       Allowable disproportionate share percentage (see instructions)       8.85       33.00		If the amount on line 24 is greater than -0-, then enter the	lower of line 23 or line	e 24 (see		1
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)       0.00       28. 01         29. 00       Total IME payment (sum of lines 22 and 28)       0.00       29. 00         29. 01       Disproportionate Share Adjustment       0.000000       29. 01         30. 00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       4.38       30. 00         31. 00       Percentage of Medicaid patient days (see instructions)       19. 42       31. 00         32. 00       Sum of lines 30 and 31       23. 80       32. 00         33. 00       Allowable disproportionate share percentage (see instructions)       8. 85       33. 00	26 00				0 000000	26 00
28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Disproportionate Share Adjustment days to Medicare Part A patient days (see instructions)  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  30.00 Sum of lines 30 and 31  30.00 Allowable disproportionate share percentage (see instructions)  31.00 Allowable disproportionate share percentage (see instructions)  32.00 Allowable disproportionate share percentage (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)		, , , , , , , , , , , , , , , , , , ,				
28.01 IME add-on adjustment amount - Managed Care (see instructions)  7		, , , , , , , , , , , , , , , , , , , ,				
29.00 Total IME payment (sum of lines 22 and 28) 0 29.00  Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.38 30.00  31.00 Percentage of Medicaid patient days (see instructions) 19.42 31.00  32.00 Sum of lines 30 and 31 23.80 32.00  33.00 Allowable disproportionate share percentage (see instructions) 8.85 33.00		, , , , , , , , , , , , , , , , , , , ,	1			
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  0 29. 01  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  19. 42 31. 00  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  8. 85 33. 00		,	•)		-	
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  4.38 30.00 31.00 Percentage of Medicaid patient days (see instructions)  5.00 Sum of lines 30 and 31  6.00 Allowable disproportionate share percentage (see instructions)  8.85 33.00		Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)			29. 00
31.00Percentage of Medicaid patient days (see instructions)19.4231.0032.00Sum of lines 30 and 3123.8032.0033.00Allowable disproportionate share percentage (see instructions)8.8533.00	30 00		ationt days (see instance	rtions)	4 20	30 00
32.00   Sum of lines 30 and 31   23.80   32.00   31.00   Allowable disproportionate share percentage (see instructions)   8.85   33.00			acrent days (See FiiStfut	, LI UIIS)		ı
33.00 Allowable disproportionate share percentage (see instructions) 8.85 33.00						
						l
54. 00 purspropor cronate share adjustillerit (see Histructions) [189, 838] 34. 00		, ,				1
	54.00	prisproportionate share adjustment (see Histructions)		ı	107, 030	1 34.00

		EMORIAL HOSPITAL		u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0030	Peri od: From 01/01/2017	Worksheet E Part A	
			To 12/31/2017	Date/Time Pre 5/30/2018 9:1	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00		
	Uncompensated Care Adjustment		1.00	2. 00	
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero,	enter zero on this line) (s	0. 000000000 ee 347, 255	0. 000000000 493, 544	•
33. 02	instructions)	enter zero on this rine) (s	347, 233	473, 344	35.02
35. 03			259, 728	124, 400	•
36.00	Total uncompensated care (sum of columns 1 and 2 on line Additional payment for high percentage of ESRD beneficiar		384, 128 uah 46)		36.00
40. 00	Total Medicare discharges on Worksheet S-3, Part I exclud 652, 682, 683, 684 and 685 (see instructions)		0		40. 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 68 instructions)	32, 683, 684 an 685. (see	0		41.00
41. 01	Total ESRD Medicare covered and paid discharges excluding an 685. (see instructions)	g MS-DRGs 652, 682, 683, 68	4 O		41. 01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not q Total Medicare ESRD inpatient days excluding MS-DRGs 652 instructions)		0.00 e 0		42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 dividays)	ded by line 41 divided by 7	0. 000000		44.00
45.00	Average weekly cost for dialysis treatments (see instruct		0.00		45.00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line Subtotal (see instructions)	ne 41.01)	9, 154, 768		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MD only. (see instructions)	OH, small rural hospitals	11, 101, 491		48. 00
	jointy. (See Thatractions)			Amount	
40.00	Total payment for innationt energting costs (see instruct	-i one)		1. 00	49. 00
49. 00 50. 00	Total payment for inpatient operating costs (see instruct Payment for inpatient program capital (from Wkst. L, Pt.		)	10, 614, 810 696, 176	1
51.00	Exception payment for inpatient program capital (Wkst. L,	Pt. III, see instructions)		0	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4 Nursing and Allied Health Managed Care payment	1, line 49 see instructions)		0	52. 00 53. 00
54.00	Special add-on payments for new technologies			0	54.00
54. 01				0	54. 01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, li	ne 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, P		through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D,	Pt. IV, col. II line 200)		0 11, 310, 986	58.00
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			11, 310, 960	59. 00 60. 00
61.00	Total amount payable for program beneficiaries (line 59 m	ninus Line 60)		11, 310, 986	ł
62. 00	Deductibles billed to program beneficiaries	in has true do,		1, 107, 904	
63.00				2, 632	
64.00	Allowable bad debts (see instructions)			59, 262	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			38, 520	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		54, 790	
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			10, 238, 970	
68. 00	Credits received from manufacturers for replaced devices			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and	96). (For SCH see instruction	ns)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	enetration) adjustment (see	inatruationa)	0	70.00
70. 50 70. 87	Rural Community Hospital Demonstration Project (§410A Dem Demonstration payment adjustment amount before sequestrat	· · · · · · · · · · · · · · · · · · ·	THS tructions)	0	70. 50 70. 87
70. 87	SCH or MDH volume decrease adjustment (contractor use onl			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see			O	70.89
70. 90	HSP bonus payment HVBP adjustment amount (see instruction	and the second s		17, 809	•
70. 91	HSP bonus payment HRR adjustment amount (see instructions	•		-110	1
70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 92
70 00	HVBP payment adjustment amount (see instructions)			103, 751	70. 93
70. 93					
70. 94	HRR adjustment amount (see instructions) Recovery of accelerated depreciation			-744	70. 94 70. 95

	HENDY COUNTY NEWDUAL HOODITA		1.11.	S 5 ONG (	2550 40
Health Financial Systems CALCULATION OF REIMBURSEMENT SETTLEMENT	HENRY COUNTY MEMORIAL HOSPITA Provider (	CCN: 15-0030	Peri od: From 01/01/2017	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/30/2018 9:1	pared:
	Ti tl	e XVIII	Hospi tal	PPS	
		FFY	(yyyy)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal y the corresponding federal year for the per			2017	523, 518	70. 96
70.97 Low volume adjustment for federal fiscal y the corresponding federal year for the per			2018	131, 438	70. 97
70.98 Low Volume Payment-3	,			0	70. 98
70.99 HAC adjustment amount (see instructions)				0	70. 99
71.00 Amount due provider (line 67 minus lines 6	8 plus/minus lines 69 & 70)			11, 014, 632	71.00
71.01 Sequestration adjustment (see instructions	3)	l		220, 293	71. 01
71.02 Demonstration payment adjustment amount af	ter sequestration			0	71. 02
72.00 Interim payments	•			10, 911, 898	72.00
73.00 Tentative settlement (for contractor use o	nl y)			0	73.00
1	T:	1			I

-117, 559

170, 930 75. 00

0 92.00

74.00

0 90.00 0 91.00

0 93.00

Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and

Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)

91.00 Capital outlier from Wkst. L, Pt. I, line 2

92.00 Operating outlier reconciliation adjustment amount (see instructions)

93.00 Capital outlier reconciliation adjustment amount (see instructions)

	U Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.	10 The rate used to calculate the time value of money (see instructions)		0. 00	94.00
95.	0 Time value of money for operating expenses (see instructions)		0	95.00
96.	0 Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2. 00	
	HSP Bonus Payment Amount			
100	00 HSP bonus amount (see instructions)	1, 092, 031	368, 011	100.00
	HVBP Adjustment for HSP Bonus Payment			
101	00 HVBP adjustment factor (see instructions)	1. 0129161580	1. 0100652060	101.00
102	00 HVBP adjustment amount for HSP bonus payment (see instructions)	14, 105	3, 704	102.00
	HRR Adjustment for HSP Bonus Payment			
103	00 HRR adjustment factor (see instructions)	1. 0000	0. 9997	103.00
104	00 HRR adjustment amount for HSP bonus payment (see instructions)	0	-110	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200	00 Is this the first year of the current 5-year demonstration period under the 21st			200.00
	Century Cures Act? Enter "Y" for yes or "N" for no.			
	Cost Reimbursement			
201	00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202	00 Medicare discharges (see instructions)			202.00
203	00 Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the curren	t 5-year demons	trati on	
	peri od)			
	00 Medicare target amount			204.00
205	00 Case-mix adjusted target amount (line 203 times line 204)			205.00
206	00 Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207	00 Program reimbursement under the §410A Demonstration (see instructions)			207.00
208	00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209	00 Adjustment to Medicare IPPS payments (see instructions)			209. 00
210	00 Reserved for future use			210.00
211	00 Total adjustment to Medicare IPPS payments (see instructions)			211. 00
	Comparision of PPS versus Cost Reimbursement			
212	00 Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
213	00 Low-volume adjustment (see instructions)		ļ	213.00
218	00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)		ļ	218. 00
	(line 212 minus line 213) (see instructions)			

74.00

75.00

73)

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2017 Part A Exhi bit 4 To 12/31/2017 Date/Time Prepared: Provider CCN: 15-0030

					To	12/31/2017	Date/Time Pre 5/30/2018 9:1	
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1.00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	6, 099, 629	0	6, 099, 629		6, 099, 629	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	2, 480, 634	0		2, 480, 634	2, 480, 634	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for	2. 00	539	0	539	0	539	2. 00
2. 01	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier	2. 01	0	0	О	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
	Indirect Medical Education Adj					,		
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	0	0	6. 01
	Indirect Medical Education Adj	ustment for th			the MMA			l
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	О	0	0	0	O	9. 01
	8.01) Disproportionate Share Adjustm	L ent						
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0885	0. 0885	0. 0885	0. 0885		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	189, 838	0	134, 954	54, 884	189, 838	11. 00
11. 01	Uncompensated care payments	36.00	384, 128	0	259, 728	124, 400	384, 128	11. 01
12. 00	Additional payment for high pe Total ESRD additional payment (see instructions)	rcentage of ESI 46.00	RD beneficiary 0	di scharges 0	0	0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	9, 154, 768 11, 101, 491	0	6, 494, 850 7, 914, 974	2, 659, 918 3, 186, 517	9, 154, 768 11, 101, 491	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	10, 614, 810	0	7, 559, 943	3, 054, 867	10, 614, 810	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	696, 176	0	494, 173	202, 003	696, 176	16. 00
17. 00	if applicable) Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	0	17. 01 17. 02

Heal th	Financial Systems	HE	NRY COUNTY MEM	ORIAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
LOW VC	DLUME CALCULATION EXHIBIT 4			Provi der C		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 9:1	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A		Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After	through 4)	
						10/01		
		0	1. 00	2.00	3.00	4.00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0	0	18. 00
19.00	SUBTOTAL			0	8, 054, 11	6 3, 256, 870	11, 310, 986	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	695, 890	0	493, 88	7 202, 003	695, 890	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0	0	20. 01

Provider CCN: 15-0030

Peri od:

From 01/01/2017

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Part A Exhibit 5

Date/Time Prepared: 5/30/2018 9:13 am 12/31/2017 Hospi tal Title XVIII Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 6,099,629 6,099,629 6, 099, 629 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 1 02 2, 480, 634 2, 480, 634 2, 480, 634 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1 04 0 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 539 539 539 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 C 0 0 2.01 **BPCI** 3.00 2.01 O 0 3.00 Operating outlier reconciliation Managed care simulated payments 4.00 4.00 3.00 0 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 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0. 000000 7.00 IME payment adjustment factor (see 27.00 0.000000 0.000000 7.00 instructions) IME adjustment (see instructions) 8 00 28 00 8 00 0 0 8.01 IME payment adjustment add on for managed 28. 01 C 0 0 0 8.01 care (see instructions) 9 00 Total IME payment (sum of lines 6 and 8) 29. 00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 0 0 9.01 C 0 lines 6.01 and 8.01) Disproportionate Share Adjustment 0. 0885 10.00 Allowable disproportionate share percentage 33.00 0.0885 0.0885 10.00 (see instructions) Di sproporti onate share adjustment (see 189, 838 11.00 34.00 134.954 54.884 189.838 11.00 instructions) 11.01 Uncompensated care payments 36.00 384, 128 259, 728 124, 400 384, 128 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12.00 12.00 46.00 instructions) 13.00 Subtotal (see instructions) 47.00 9, 154, 768 6, 494, 850 2, 659, 918 9, 154, 768 13.00 Hospital specific payments (completed by SCH 48.00 11, 101, 491 14.00 14.00 and MDH, small rural hospitals only.) (see instructions) 10, 614, 810 7, 954, 892 Total payment for inpatient operating costs 49.00 2, 659, 918 10, 614, 810 15.00 15.00 (see instructions) 16,00 Payment for inpatient program capital (from 50.00 696, 176 494.173 202,003 696, 176 16.00 Wkst. L, Pt. I, if applicable)
Special add-on payments for new technologies 17.00 0 17.00 54 00 0 0 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for 68.00 0 0 0 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18.00 93.00 0 amount (see instructions) 19. 00 | SUBTOTAL 8, 449, 065 2, 861, 921 11, 310, 986 19.00

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
HOCOL TAL ACCUL DED COMPLETION (HA	O) DEDUCTION ON OUR ATLON EVALUE F	D	D	We do by the F

Health Financial Systems H	ENRY COUNTY MEN	<u>IORI AL HOSPI TAL</u>		In Lie	eu of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCUL	ATION EXHIBIT 5			Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 9:1	pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2. 00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	695, 890	493, 88	7 202, 003	695, 890	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0	-	0	0	1
21.00 Capital DRG outlier payments	2. 00	286	28	6 0	286	
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0	20	0	0	21.01
22.00 Indirect medical education percentage (see	5. 00	0. 0000	0. 000	0. 0000		22.00
instructions)						
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. 0000	0. 000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11. 00	0		0 0	0	25. 00
26.00 Total prospective capital payments (see	12. 00	696, 176	494, 17	3 202, 003	696, 176	26.00
instructions)						
	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	523, 518	523, 51	8	523, 518	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	131, 438		131, 438	131, 438	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	103, 751	78, 78	3 24, 968	103, 751	30.00
30.01 HVBP payment adjustment for HSP bonus	70. 90	17, 809	14, 10	5 3, 704	17, 809	30. 01
payment (see instructions)		,			, , , , ,	
31.00 HRR adjustment (see instructions)	70. 94	-744		0 -744	-744	31.00
31.01 HRR adjustment for HSP bonus payment (see	70. 91	-110		0 -110		
i nstructi ons)	75.7.					
					(Amt. to	
					Wkst. E, Pt. A)	
	0	1.00	2. 00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0		32.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.	D	N				100.00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0030	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/30/2018 9:13 am

Mail B - WeblickL Abid Dilber Havill Standers   1.00				10 12/31/2017	5/30/2018 9:1	
Mark   Minical AMD DIVIEW HAT IN SISPLICES   1,055			Title XVIII	Hospi tal		J dili
Mark   Minical AMD DIVIEW HAT IN SISPLICES   1,055						
					1. 00	
Medical and other services reinbursed under OPPS (see instructions)	1 00				1 (52	1 00
0.000   OPPS payments		1	ctions)			
0.00   Outlier   payment (see instructions)   7, 401   4.1		· ·	,trons)			
Autilier   reconcilitation amount (see instructions)		, , ,				4.00
Enter the hospital specific payment to cost ratio (see Instructions)   0.000   5.		, , ,				4. 01
Line 2 tines in les		,	uctions)			
17.00   Transitional corridor payment (see instructions)   0   0   0   0   0   0   0   0   0			,			
9.00   Ancillary service other pass through costs from Wist. D. Pt. IV. col. 13, Iline 200   0   9, 100   100   00   00   00   00   100	7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
0   00   07gan acquist from   0   10.1   10.5   1	8.00	Transitional corridor payment (see instructions)			0	8.00
1.10   10   Total cost (sum of lines 1 and 10) (see instructions)   1.653   1.052	9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.00
COMPUTATION OF LESSER OF COST OR CHARCES   Reasonable charges   Reasonable   Reasonable charges   Reasonable cha					-	10.00
Reasonable charges   Reasonable charges   3,774   12,00   April 11 my service charges   3,774   13,00   13,11   14,00   Total reasonable charges (stim of lines 12 and 13)   0   13,374   14,00   Total reasonable charges (stim of lines 12 and 13)   15,10   16,00	11. 00				1, 653	11.00
12.00   Ancil lary service charges   3, 774   12.10						
13.00   Organ acquisition charges (from West. D-4, Pt. IIII, col. 4, line 69)   0   13.	10.00				2 774	12 00
14.00   Total reasonable charges (sum of lines 12 and 13)   24.			ino (0)			
Outcomerry charges			THE 69)			
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.00   Amounts that would have been real ized from patients liable for payment for services on a chargebasis   0   16.10   Amounts that would have been repatients liable for payment for services on a chargebasis   0   16.10   17.00   20.00   17.00   20.00   17.00   20.00   17.00   20.00	14.00				3,774	14.00
16.00   Anounts that would have been realized from patients liable for payment for services on a chargebasis had buch payment been made in accordance with 42 CFR \$413.13(e)   0.000000   17.10.00	15. 00		payment for services on	a charge basis	0	15.00
had such payment been made in accordance with 42 CPR §413. 13(e)*   0.000000   17.00   Ratio of line 15 to line 16 (not to exceed 1.000000)   17.00   17.00   Ratio of line 15 to line 16 (not to exceed 1.000000)   17.00						
18.00   Total customary charges (see instructions)   3,774   18.				· ·		
19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)   20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)   1.653   21.	17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
Instructions    2.0.0   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   2.0.0   1.1.653   21.0   22.0	18.00	Total customary charges (see instructions)			3, 774	18.00
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)   1,653   21.	19. 00		nly if line 18 exceeds li	ne 11) (see	2, 121	19.00
Instructions    1,653   21.1   22.0   21.0   1.0   1.0   22.0   22.0   1.0   1.0   1.0   22.0   1.0   1.0   1.0   22.0   1.0   1.0   1.0   22.0   1.0   1.0   1.0   22.0	00.00			10) (		00.00
1,653   21.00   Lesser of cost or charges (see instructions)   0.22.00   0	20.00	, , , , , , , , , , , , , , , , , , , ,	nly it line il exceeds il	ne 18) (see	0	20.00
22.20   Interns and residents (see instructions)   0 22.	21 00				1 452	21 00
23.00   Cost of physicians' services in a teaching hospital (see instructions)   6,964,479   24.10   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   6,964,479   24.10   CoMPUTATION OF REIMBURSEMENT SETTLEMENT		,				
24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   6,964,479   24.		· · · · · · · · · · · · · · · · · · ·	ructions)			23.00
COMPUTATION OF REINBURSEMENT SETTLEMENT   Deductible sand coinsurance (for CAH, see instructions)   0   25.					-	
26.00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   1, 372, 670   26.7						
26.00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   1, 372, 670   26.7	25.00	Deductibles and coinsurance (for CAH, see instructions)			0	25.00
Instructions	26.00		or CAH, see instructions	)	1, 372, 670	26.00
28.00   Direct graduate medical education payments (From Wkst. E-4, line 50)   29.00   ESRD direct medical education costs (From Wkst. E-4, line 36)   29.00	27.00		plus the sum of lines 22	2 and 23] (see	5, 593, 462	27.00
29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   5, 593, 462   30.						
30. 00   Subtotal (sum of lines 27 through 29)   5,593,462   30. 03   31. 00   Primary payer payments   3,132   31. 00   Subtotal (line 30 minus line 31)   5,590,330   32. 00   Subtotal (line 30 minus line 31)   5,590,330   32. 00   Subtotal (line 30 minus line 31)						
31.00   Primary payer payments   3, 132   31.00   Subtotal (line 30 minus line 31)   5,590,330   32.00   Subtotal (line 30 minus line 31)   5,590,330   32.00   Allowable BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00   33.00   Allowable bad debts (see instructions)   106,101   35.00   36.00   Allowable bad debts (see instructions)   106,001   35.00   36.00   Allowable bad debts (see instructions)   106,005   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   106,005   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   106,005   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   106,005   36.00   37		1				
Subtotal (line 30 minus line 31)						
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. 1-5, line III)   0   33.40   34.00   Allowable bad debts (see instructions)   163, 233   34.01   35.00   Adjusted reimbursable bad debts (see instructions)   106, 101   35.01   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   160, 054   36.01   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   5, 696, 431   37.00   Subtotal (see instructions)   5, 696, 431   37.00   Subtotal (see instructions)   1, 068   38.00   MSP-LCC reconciliation amount from PS&R   1, 068   38.00   MSP-LCC reconciliation amount before sequestration   39.00   39.00   MSP-LCC reconciliation amount before sequestration   39.00   39.00   39.00   MSP-LCC reconciliation amount before sequestration   39.00   39.00   39.00   MSP-LCC reconciliation amount from PS&R   1, 068   38.00   39.00   39.00   MSP-LCC reconciliation amount from PS&R   1, 068   38.00   39.00   39.00   MSP-LCC reconciliation amount from PS&R   1, 068   39.00   39.00   MSP-LCC reconciliation amount from PS&R   1, 068   39.00   39.00   MSP-LCC reconciliation amount from PS&R   1, 07.00   39.00   39.00   MSP-LCC reconciliation amount from PS&R   1, 07.00   39.00   39.00   MSP-LCC reconciliation amount from PS&R   1, 07.00   39.0						
33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   34.00   All lowable bad debts (see instructions)   163,233   34.00   34.00   All lowable bad debts (see instructions)   106,101   35.00   35.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   160,054   36.01   37.00   37.00   Subtotal (see instructions)   5,696,431   37.01   37.00	32.00		CES)		3, 370, 330	32.00
34.00	33.00	•	920)		0	33.00
36. 00		1				
37. 00 Subtotal (see instructions) 38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 90 Subtotal (see instructions) 39. 91 Sequestration adjustment (see instructions) 39. 92 OFTHIS ADDITION 39. 90 Subtotal (see instructions) 39. 90 Sequestration adjustment (see instructions) 39. 90 OFTHIS ADDITION 39. 90	35.00	Adjusted reimbursable bad debts (see instructions)			106, 101	35.00
38.00       MSP-LCC reconciliation amount from PS&R       1,068       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.30         39.50       Pioneer ACO demonstration payment adjustment (see instructions)       39.43         39.97       Demonstration payment adjustment amount before sequestration       0       39.43         39.98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39.43         40.01       Sequestration adjustment (see instructions)       5,695,363       40.41         40.01       Sequestration adjustment (see instructions)       5,695,363       40.41         40.02       Demonstration payment adjustment amount after sequestration       0       40.41         41.00       Interim payments       5,654,384       41.41         42.00       Tentative settlement (for contractors use only)       0       42.41         43.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0       44.61         §115.2       TO BE COMPLETED BY CONTRACTOR       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00 </td <td>36.00</td> <td>Allowable bad debts for dual eligible beneficiaries (see inst</td> <td>ructions)</td> <td></td> <td>160, 054</td> <td>36.00</td>	36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		160, 054	36.00
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pi oneer ACO demonstrati on payment adjustment (see instructions) 39.70 Demonstrati on payment adjustment amount before sequestration 39.81 Sq. 91 Sq. 92 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.90 RECOVERY OF ACCELERATED DEPRECIATION 39.91 Subtotal (see instructions) 39.92 Sq. 90 Subtotal (see instructions) 39.93 Sq. 90 Subtotal (see instructions) 39.94 Sq. 90 S	37.00	Subtotal (see instructions)				
39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 39. 90 Subtotal (see instructions) 39. 90 Sequestration adjustment (see instructions) 39. 90 Demonstration payment (see instructions) 39. 90 Demonstration payment (see instructions) 39. 90 Demonstration adjustment (see instructions) 39. 90 Demonstration payment adjustment amount after sequestration 39. 90 Demonstration adjustment amount after sequ	38. 00				1, 068	38.00
39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 90 Subtotal (see instructions) 39. 90 Sequestration adjustment (see instructions) 39. 90 Demonstration payment adjustment amount after sequestration 39. 90 Online Completed amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, possible Completed amount (see instructions) 39. 90 Online contractors used instructions) 39. 90 Online contractors used instructions) 39. 90 Online contractors used instructions 39. 90 Online contractors us					0	39.00
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 99 RECOVERY OF ACCELERATED DEPRECIATION  39. 94 40. 00 Subtotal (see instructions)  5, 695, 363 40. 01  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  113, 907 40. 02  110 Interim payments  Tentative settlement (for contractors use only)  Balance due provider/program (see instructions)  41. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2  TO BE COMPLETED BY CONTRACTOR  90. 00 Original outlier amount (see instructions)  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  Time Value of Money (see instructions)  0 39. 39. 40. 40. 40. 40. 40. 40. 40. 40. 40. 40			ns)			39.50
39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       5, 695, 363       40. 01         40. 01       Sequestration adjustment (see instructions)       113, 907       40. 0         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 0         41. 00       Interim payments       5, 654, 384       41. 0         42. 00       Tentative settlement (for contractors use only)       0       42. 0         43. 00       Balance due provider/program (see instructions)       -72, 928       43. 0         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515. 2       0       44. 0         90. 00       Original outlier amount (see instructions)       0       90. 0         91. 00       Outlier reconciliation adjustment amount (see instructions)       0       91. 0         92. 00       The rate used to calculate the Time Value of Money       0. 00       92. 0         93. 00       Time Value of Money (see instructions)       0       93. 0						
40.00       Subtotal (see instructions)       5, 695, 363       40.01         40.01       Sequestration adjustment (see instructions)       113, 907       40.01         40.02       Demonstration payment adjustment amount after sequestration       0 40.01         41.00       Interim payments       5, 654, 384       41.0         42.00       Tentative settlement (for contractors use only)       -72, 928       43.00         44.00       Bal ance due provider/program (see instructions)       -72, 928       43.00         44.00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2       0       44.00         90.00       Original outlier amount (see instructions)       0       90.0         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.0         92.00       The rate used to calculate the Time Value of Money       0.00       92.0         93.00       Time Value of Money (see instructions)       0       93.0		·	aced devices (see instru	ctions)		
40.01       Sequestration adjustment (see instructions)       113,907       40.02         40.02       Demonstration payment adjustment amount after sequestration       0 40.0         41.00       Interim payments       5,654,384       41.0         42.00       Tentative settlement (for contractors use only)       0 42.0         43.00       Balance due provider/program (see instructions)       -72,928       43.0         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2       0       44.0         90.00       Original outlier amount (see instructions)       0       90.0         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.0         92.00       The rate used to calculate the Time Value of Money       0.00       92.0         93.00       Time Value of Money (see instructions)       0       93.0						39. 9
40.02 Demonstration payment adjustment amount after sequestration  40.02 Interim payments  5,654,384 41.0  42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{1}{5}\$115.2  \$\frac{1}{10}\$ BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  0 utlier reconciliation adjustment amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  1 pub. 40.00  90.00 Outlier reconciliation adjustment amount (see instructions)  1 pub. 40.00  90.00 Outlier reconciliation adjustment amount (see instructions)  1 pub. 40.00  90.00 Outlier reconciliation adjustment amount (see instructions)  1 pub. 40.00  90.00 Outlier reconciliation adjustment amount (see instructions)  1 pub. 40.00  90.00 Outlier reconciliation adjustment amount (see instructions)  1 pub. 40.00  90.00 Outlier reconciliation adjustment amount (see instructions)  1 pub. 40.00  90.00 Outlier reconciliation adjustment amount (see instructions)  1 pub. 40.00  90.00 Outlier reconciliation adjustment amount (see instructions)  1 pub. 40.00  90.00 Outlier reconciliation adjustment amount (see instructions)  1 pub. 40.00  90.00 Outlier reconciliation adjustment amount (see instructions)  1 pub. 40.00  90.00 Outlier reconciliation adjustment amount (see instructions)  1 pub. 40.00  90.00 Outlier reconciliation adjustment amount (see instructions)		1				
41.00       Interim payments       5,654,384       41.0         42.00       Tentative settlement (for contractors use only)       0       42.0         43.00       Balance due provider/program (see instructions)       -72,928       43.0         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2       0       44.0         90.00       Original outlier amount (see instructions)       0       90.0         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.0         92.00       The rate used to calculate the Time Value of Money       0.00       92.0         93.00       Time Value of Money (see instructions)       0       93.0						
42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (see instructions)  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  10 90.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) protested amounts (no						
43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{5115.2}{10 BE COMPLETED BY CONTRACTOR}\$  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 Og 93.00		' '				
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00		,				
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 93.00 Time Value of Money (see instructions) 0 93.00		, , , , , , , , , , , , , , , , , , , ,	ance with CMS Pub. 15-2.	chapter 1.		
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 O 95.00 O 95		,		-1		
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00 92.00 93.00 93.00 Time Value of Money (see instructions)						
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00 93.00 93.00 93.00	90.00	Original outlier amount (see instructions)			-	
93.00 Time Value of Money (see instructions) 0 93.00		•				1
94.00   Total (sum of lines 91 and 93)		,				
	94.00	Total (sum of lines 91 and 93)			0	94.0

Health Financial Systems HENRY CANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2017 | Part I | Date/Time Prepared: | To 12/31/2017 | Date/Time Prep Provi der CCN: 15-0030

				0 12/31/201/	5/30/2018 9:1	
		Title	: XVIII	Hospi tal	PPS	o aiii
			it Part A		⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	Transfer to the decision of the court to the	1.00	2.00	3. 00	4. 00	4 00
1.00	Total interim payments paid to provider Interim payments payable on individual bills, either		10, 271, 913		5, 476, 309 0	1. 00 2. 00
2.00	submitted or to be submitted to the contractor for				0	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			_		
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2017	36, 934		178, 075	3. 01
3. 02		07/07/2017	35, 500		0	3. 02
3. 03		40 (04 (0047	427 443		0	3. 03
3. 04		12/31/2017	436, 113		0	3. 04
3. 05	Provider to Program	12/31/2017	131, 438	1	0	3. 05
3. 50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51	ADJUST WIENTS TO TROOKAW	•			0	3. 51
3. 52					0	3. 52
3. 53			l o		0	3. 53
3.54			l c		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		639, 985		178, 075	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		10, 911, 898		5, 654, 384	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after	T	T			5. 00
5.00	desk review. Also show date of each payment. If none.					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			0	1	0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52	C.ht-t-1 (6 1)		0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		117, 559		72, 928	6. 02
7. 00	Total Medicare program liability (see instructions)		10, 794, 339		5, 581, 456	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	To the second se	(	)	1. 00	2. 00	
8. 00	Name of Contractor			1	[	8.00

Heal th	Financial Systems HENRY COUNTY MEMOR	I AL HOSPI TAL	In Lie	u of Form CMS-	2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0030	Peri od: From 01/01/2017	Worksheet E-1	1		
			To 12/31/2017				
		Title XVIII	Hospi tal	PPS			
				1. 00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1.00		
	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12						
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1	3. 00		
4. 00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	8-12		i	4.00		
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1	5. 00		
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 I			1	6. 00		
7. 00	CAH only - The reasonable cost incurred for the purchase of a line 168	certified HIT technology	Wkst. S-2, Pt. I	ı	7. 00		
8.00	Calculation of the HIT incentive payment (see instructions)			1	8.00		
9.00	Sequestration adjustment amount (see instructions)			1	9.00		
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		i	10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH						
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00		
31.00	Other Adjustment (specify)			i	31.00		
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	line 31) (see instructio	ns)		32.00		

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0030	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2018 9:13 am

			Γο 12/31/2017	5/30/2018 9:1	
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	ES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1. 00	Inpatient hospital/SNF/NF services		282, 917		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)		282, 917	0	4.00
5. 00	Inpatient primary payer payments		0	_	5.00
6. 00	Outpatient primary payer payments		200 047	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		282, 917	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
8. 00	Reasonable Charges		207 720		0 00
9. 00	Routine service charges Ancillary service charges		207, 720 308, 027	0	8. 00 9. 00
10. 00	Organ acquisition charges, net of revenue		300, 027	U	10.00
	Incentive from target amount computation		0		11.00
	Total reasonable charges (sum of lines 8 through 11)		515, 747	0	
12.00	CUSTOMARY CHARGES		313, 747	0	12.00
13. 00	Amount actually collected from patients liable for payment for se	ervices on a charge	0	0	13.00
	basis	g-		_	
14.00	Amounts that would have been realized from patients liable for par	ayment for services or	0	0	14.00
	a charge basis had such payment been made in accordance with 42 Cl	CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		515, 747	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only i	f line 16 exceeds	232, 830	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only i	fline 4 exceeds line	0	0	18. 00
40.00	16) (see instructions)				40.00
	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instruct	(i ons)	202 017	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	anlated for DDS provis	282, 917	0	21.00
22 00	Other than outlier payments	ipreted for PPS provid	0	0	22. 00
	Outlier payments		0	0	23. 00
	Program capital payments		0	O	24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	26. 00
	Subtotal (sum of lines 22 through 26)		0	0	27. 00
	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
	Titles V or XIX (sum of lines 21 and 27)		282, 917	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		282, 917	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00			0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	_	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	3)	282, 917	0	36.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		000 017	0	
	Subtotal (line 36 ± line 37)	282, 917	0		
39.00	Direct graduate medical education payments (from Wkst. E-4)	202 017	0	39.00	
40.00	Total amount payable to the provider (sum of lines 38 and 39) Interim payments	282, 917 253, 858	0	40. 00 41. 00	
41.00	Balance due provider/program (line 40 minus line 41)		29, 059	0	41.00
	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2	27, U39	0	42.00
43.00	chapter 1, §115. 2	W. C.I. OWO 1 GD 13-2,		O	75.00
	1		'		•

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: 15-0030

Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/30/2018 9:13 am

		Caranal Fund	C: 6: -	F	5/30/2018 9: 1	3 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-1, 451, 713	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts recei vable	16, 230, 548		0	0	4. 00
5. 00	Other recei vable	0	0	0	0	
6. 00	Allowances for uncollectible notes and accounts receivable		0	0	0	6. 00
7. 00	Inventory	715, 864		0	0	
8. 00	Prepai d expenses	1, 061, 003		0	0	8.00
9. 00 10. 00	Other current assets Due from other funds	1, 545, 598	1	0	0	9.00
11. 00	Total current assets (sum of lines 1-10)	46, 298, 434 64, 399, 734		0		
11.00	FIXED ASSETS	04, 377, 734		<u> </u>	0	111.00
12. 00	Land	46, 000	ol ol	0	0	12.00
13. 00	Land improvements	2, 068, 316		0		
14. 00	Accumul ated depreciation	-1, 389, 099		0	0	14. 00
15. 00		40, 575, 749		0	0	15. 00
16. 00	Accumulated depreciation	-28, 029, 655		0	0	16. 00
17. 00		1, 098, 114		0	0	17. 00
18. 00	· •	-986, 045		0	0	18. 00
	Fi xed equipment	18, 784, 226		0	0	19.00
20.00		-13, 908, 595	0	0	0	20.00
21.00		0	0	0	0	21.00
22.00		0	o	0	0	22.00
23.00		39, 568, 068	0	0	0	23.00
24.00		-24, 074, 134	. 0	0	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27. 00
28.00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	, ,	33, 752, 945	0	0	0	30.00
	OTHER ASSETS					
31. 00	Investments	10, 714, 778		0	0	
32.00	Deposits on Leases	0	0	0	0	
33. 00	Due from owners/officers	0	0	0	0	
34.00		7, 393, 010		0	0	
35.00	Total other assets (sum of lines 31-34)	18, 107, 788		0		
36. 00	Total assets (sum of lines 11, 30, and 35)	116, 260, 467	0	0	0	36.00
37. 00	CURRENT LIABILITIES Accounts payable	7, 901, 792	. 0	0	0	37.00
38. 00	Salaries, wages, and fees payable	4, 361, 517		0		
39. 00	Payroll taxes payable	4,301,317		0	0	1
	Notes and Loans payable (short term)	947, 100		0	0	
41. 00	Deferred income	747, 100		0	0	
42. 00				O		42.00
43. 00	Due to other funds	19, 208, 234	0	0	0	1
44. 00		0		0	Ö	
	Total current liabilities (sum of lines 37 thru 44)	32, 418, 643		0		
	LONG TERM LIABILITIES	0=//				
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	1
48.00	Unsecured Loans	0	0	0	0	1
49.00	Other long term liabilities	14, 696, 939	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14, 696, 939	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	47, 115, 582	. 0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	69, 144, 885	)			52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00				0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
FO 00	replacement, and expansion	/0 444 605		_	_	F0 00
59.00	Total fund balances (sum of lines 52 thru 58)	69, 144, 885		0	0	
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	116, 260, 467	0	0	0	60.00
	1977	I	1		I	I

16.00 17.00

18.00

19.00

In Lieu of Form CMS-2552-10 STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-0030 Peri od: Worksheet G-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/30/2018 9:13 am General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 2.00 3. 00 4.00 1.00 Fund balances at beginning of period 73, 650, 344 0 1.00 Net income (loss) (from Wkst. G-3, line 29) -4, 505, 459 2.00 2.00 3.00 Total (sum of line 1 and line 2) 69, 144, 885 ol 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 5.00 0000 0 5.00 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 Subtotal (line 3 plus line 10) 69, 144, 885 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 00000 13.00 0 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 69, 144, 885 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 0 3.00 3.00 Total (sum of line 1 and line 2) 0 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 6.00 0 6.00 0 7.00 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 0 13.00 14.00 0 14.00 15.00 15.00

0

0

0

0

16.00

17.00

18.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

Health Financial Systems HENR STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0030 

			10 12/31/201/	Date/IIme Pre   5/30/2018 9:1	
	Cost Center Description	Inpatient	Outpati ent	Total	
		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	12, 002, 58	6	12, 002, 586	1.00
2.00	SUBPROVIDER - IPF				2.00
3. 00	SUBPROVI DER - I RF			0	3.00
4. 00	SUBPROVI DER			0	4.00
5. 00	Swing bed - SNF			0	5.00
6.00	Swing bed - NF	'		0	6.00
7.00	SKILLED NURSING FACILITY NURSING FACILITY				7.00
8. 00 9. 00	OTHER LONG TERM CARE				8. 00 9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	12, 002, 58	١	12, 002, 586	10.00
10.00	Intensive Care Type Inpatient Hospital Services	12,002,50	اا	12, 002, 360	10.00
11. 00	INTENSIVE CARE UNIT	4, 928, 15	9	4, 928, 159	11. 00
12. 00	CORONARY CARE UNIT	1, 720, 10		1,720,107	12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	s 4, 928, 15	9	4, 928, 159	16.00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	16, 930, 74		16, 930, 745	17. 00
18. 00	Ancillary services	42, 712, 86		142, 934, 168	18. 00
19. 00	Outpati ent servi ces	1, 722, 91		17, 386, 937	19. 00
20.00	NEW CASTLE FAMILY & INTERNAL MED		3, 138, 758	3, 138, 758	20.00
20. 01	NCFIM- NORTHFIELD PARK		730, 683	730, 683	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	'	0 700 4 7	0	21.00
22. 00	HOME HEALTH AGENCY		2, 723, 167	2, 723, 167	22.00
23. 00	AMBULANCE SERVICES				23.00
24. 00 25. 00	CMHC				24. 00 25. 00
26. 00	HOSPICE		1, 878, 397	1, 878, 397	26.00
27. 00	NONREI MBURSABLE	74		1, 485, 086	27.00
27. 00	OTHER		9, 658	9, 658	27. 00
27. 01	PRO FEES		19, 143, 860	19, 143, 860	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to W			206, 361, 459	28. 00
	G-3, line 1)		,,		
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		90, 563, 312		29. 00
30.00	ADD (SPECIFY)		)		30.00
31. 00					31. 00
32.00					32.00
33.00					33.00
34.00		I			34.00
35.00	Total additions (over all lane 20.25)	'			35.00
36. 00 37. 00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)		0		36. 00 37. 00
38.00	DEDUCT (SPECIFY)				38.00
39. 00					39. 00
40.00					40.00
41. 00					41. 00
42.00	Total deductions (sum of lines 37-41)		اً		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	ansfer	90, 563, 312		43. 00
	to Wkst. G-3, line 4)				

	Financial Systems HENRY COUNTY MEMOR			u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0030	Peri od:	Worksheet G-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 9:1	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, Ii			206, 361, 459	1.00
2.00	Less contractual allowances and discounts on patients' accou	nts		123, 593, 733	2.00
3.00	Net patient revenues (line 1 minus line 2)			82, 767, 726	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		90, 563, 312	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-7, 795, 586	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			1, 234, 457	7.00
8.00	Revenues from telephone and other miscellaneous communicatio	n services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	INVESTMENT INCOME			6, 243, 116	24.00
24. 01	OTHER NONOPERATING			-4, 187, 446	24. 01
25.00	Total other income (sum of lines 6-24)			3, 290, 127	25. 00
26 00	Total (line 5 plus line 25)			4 505 450	26 00

-4, 505, 459 26. 00

0 0 28.00 -4,505,459 29.00

27.00

24.00 INVESIMENT INCOME
24.01 OTHER NONOPERATING
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
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)

1, 415, 258

-15, 593

1, 399, 665

24.00

24.00 Total (sum of lines 1-23)

Heal th	Financial Systems	HE	NDV COUNTY MEN	MORIAL HOSPITAL		In lie	eu of Form CMS-:	2552_10
	ALLOCATION - HHA STATISTICAL BAS		NICT COUNTY WEN		CN: 15-0030	Period: From 01/01/2017 To 12/31/2017	Worksheet H-1 Part II	pared:
						Home Health Agency I	PPS	
		Capital Rel	ated Costs					
		BI dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliatio n	Administrativ e & General (ACCUM. COST)	
		1. 00	2. 00	3.00	4.00	5A. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS  Capital Related - Bldg. &  Fixtures	0				0		1.00
2. 00	Capital Related - Movable Equipment		0			0		2. 00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4. 00	Transportation (see instructions)	0	0	0		0		4. 00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	0	0	0		0 -444, 349	955, 316	5. 00
6.00	Skilled Nursing Care	0	0	0		0 0	577, 946	6.00
7.00	Physical Therapy	0	0	0		0 0	293, 654	
8.00	Occupational Therapy	0	0	0		0	53, 116	
9. 00	Speech Pathology	0	0	0		0	4, 914	
10.00	Medical Social Services	0	0	0	1	0	0	10.00
11.00	Home Heal th Ai de	0	0	0	1	0	25, 686	
12.00	Supplies (see instructions)	0	0	0	1	0	0	12.00
13.00	Drugs	0	0	0	1	0	0	13.00

0.000000

0

0.000000

0

0

0

0

0

0

0.000000

0

0

0.000000

-444, 349

14.00

15.00

16.00

17.00

18.00

19.00

20.00

21.00

22.00

23.00

23.50

24.00 25.00

955, 316 444, 349

0. 465133 26. 00

14.00

15.00

16.00

17.00

18.00

19.00

20.00

21.00

22.00

23.00

23.50

24.00

25.00

Clinic

HHA NONREIMBURSABLE SERVICES

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program Homemaker Service

Total (sum of lines 1-23) Cost To Be Allocated (per

Worksheet H-1, Part I) 26.00 Unit Cost Multiplier

Respiratory Therapy

Day Care Program

Tel emedi ci ne

Private Duty Nursing

All Others (specify)

Date/Time Prepared:

Part I

5/30/2018 9:13 am Home Health PPS Agency I CAPITAL RELATED COSTS NEW BLDG & NEW MVBLE **EMPLOYEE** ADMI NI STRATI V Cost Center Description HHA Trial Subtotal Bal ance (1) FI XT EQUI P **BENEFITS** E & GENERAL DEPARTMENT 1. 00 5. 00 0 2.00 4. 00 4A 1.00 Administrative and General 00 293, 218 58. 474 1.00 293, 218 2.00 Skilled Nursing Care 846, 768 0 846, 768 168, 863 2.00 Physical Therapy 430, 242 0 430, 242 85, 799 3.00 000000000000000000 3.00 Occupational Therapy 77, 822 0 0 77, 822 15, 519 4.00 4.00 Speech Pathology 7, 200 5.00 7, 200 0 0 1, 436 5.00 6.00 Medical Social Services 0 0 6.00 7.00 Home Heal th Aide 37,633 37, 633 7,505 7.00 0 0 8.00 8 00 Supplies (see instructions) Ω 0 0 0 9.00 Drugs C 0 9.00 10.00 DMF 0 10.00 0 11.00 Home Dialysis Aide Services 0 0 0 11.00 0 Respiratory Therapy 0 12 00 12 00 Private Duty Nursing 13.00 0 0 13.00 14.00 0 14.00 Clinic Health Promotion Activities 0 0 15.00 15.00 0 0 Day Care Program 0 16.00 16.00 Ω 17.00 Home Delivered Meals Program 0 0 0 0 17.00 Homemaker Service 0 18.00 0 0 0 18.00 All Others (specify) 0 0 19 00 0 19 00 0 0 19.50 Tel emedi ci ne 0 C 0 19.50 Total (sum of lines 1-19) (2) 1, 399, 665 293, 218 1, 692, 883 337, 596 20.00 20.00 21.00 Unit Cost Multiplier: column 0.000000 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places OPERATION OF LAUNDRY & HOUSEKEEPI NG NURSI NG Cost Center Description DI ETARY CAFETERI A PLANT LINEN SERVICE ADMI NI STRATI O 7. 00 8.00 13.00 9.00 10.00 11. 00 41, 345 1.00 Administrative and General 1.00 2.00 Skilled Nursing Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 2.00 0 0 Physical Therapy 3.00 C 3 00 4.00 Occupational Therapy 0000000000000000 4.00 5.00 Speech Pathology 0 0 5.00 0 0 6.00 Medical Social Services 0 6.00 0 7.00 Home Health Aide 0 7.00 8.00 Supplies (see instructions) 0 0 8.00 9.00 0 0 0 0 9.00 Drugs 0 10.00 DMF 0 0 10.00 11.00 Home Dialysis Aide Services C 0 11.00 12.00 Respiratory Therapy 12.00 13.00 Private Duty Nursing 0 0 0 0 0 13.00 0 14.00 Clinic 0 14.00 15.00 Health Promotion Activities 0 15.00 0 0 0 0 16.00 Day Care Program 0 16.00 Home Delivered Meals Program 0 0 17.00 0 17.00 0 18.00 Homemaker Service C 18.00 19.00 All Others (specify) 0 0 C 0 0 19.00 0 19.50 Tel emedi ci ne 0 19.50 20.00 20 00 Total (sum of lines 1-19) (2) 41, 345 0 21.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

Provider CCN: 15-0030

15-7430

HHA CCN:

Peri od:

From 01/01/2017

12/31/2017

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

	Financial Systems		NRY COUNTY MEMO			In Lie	u of Form CMS-2	
ALLOCA	ATION OF GENERAL SERVICE COSTS	ΓΟ HHA COST CEN	TERS	Provi der CCN	I: 15-0030	Peri od:	Worksheet H-2	
				HHA CCN:	15-7430	From 01/01/2017 To 12/31/2017	Part     Date/Time Pre	nared:
				TITIA CON.	13-7430	10 12/31/2017	5/30/2018 9: 13	
						Home Health	PPS	
						Agency I		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	Subtotal	Intern &	Subtotal	
	•	SERVICES &		RECORDS &		Resi dents		
		SUPPLY		LI BRARY		Cost & Post		
						Stepdown		
						Adjustments		
		14. 00	15. 00	16. 00	24.00	25. 00	26. 00	
1. 00	Administrative and General	5, 475	0	9, 680	408, 19		408, 192	1. 00
2. 00	Skilled Nursing Care	0	o	0	1, 015, 63		1, 015, 631	2.00
3. 00	Physi cal Therapy	ا	o	o	516, 04		516, 041	3. 00
4. 00	Occupational Therapy	ا	o	0	93, 34		93, 341	4. 00
5. 00	Speech Pathology		o	0	8, 63		8, 636	5. 00
6. 00	Medical Social Services		o	0	0, 00	0	0	6. 00
7. 00	Home Heal th Ai de	ا	o	0	45, 13	38	45, 138	7. 00
8. 00	Supplies (see instructions)		ő	Ö	10, 10	0 0	0	8. 00
9. 00	Drugs		ő	Ö			ő	9. 00
10.00	DME		Ö	Ö			ő	10.00
11. 00	Home Dialysis Aide Services		o	0			0	11. 00
12. 00	Respiratory Therapy		o	0			Ö	12.00
13. 00	Pri vate Duty Nursing		0	o			o	13. 00
14. 00	Clinic		o	0			0	14. 00
15. 00	Health Promotion Activities		0	0			o	15. 00
16. 00	Day Care Program		o	0			0	16.00
17. 00	Home Delivered Meals Program		0	0			0	17. 00
			1	0			-	18.00
18. 00 19. 00	Homemaker Service	0	0	0		0 0	0	
	All Others (specify)	0	0	0		0 0	0	19.00
19.50	Tel emedi ci ne	5 475	0	0 (00)	0.00/.0=	0	0 00/ 070	19.50
20.00	Total (sum of lines 1-19) (2)	5, 475	0	9, 680	2, 086, 97	79 0	2, 086, 979	
21. 00	Unit Cost Multiplier: column							21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.  Cost Center Description	Allocated HHA	Total HHA					
	cost center bescription	A&G (see Part	Costs					
		11)	00313					
		27. 00	28. 00					
1. 00	Administrative and General							1. 00
2. 00	Skilled Nursing Care	246, 947	1, 262, 578					2. 00
3. 00	Physical Therapy	125, 474	641, 515					3. 00
4. 00	Occupational Therapy	22, 696	116, 037					4. 00
5. 00	Speech Pathology	2, 100	10, 736					5. 00
6. 00	Medical Social Services	2, 100	10, 700					6. 00
7. 00	Home Heal th Ai de	10, 975	56, 113					7. 00
8. 00	Supplies (see instructions)	10, 770	0					8. 00
9. 00	Drugs		0					9. 00
10. 00	DME		0					10.00
11. 00	Home Dialysis Aide Services		0					11.00
12. 00	Respiratory Therapy		0					12.00
13. 00	Pri vate Duty Nursing		0					13.00
14. 00	Clinic		o					14.00
15. 00	Health Promotion Activities		0					15.00
16. 00	Day Care Program		0					16.00
17. 00	Home Delivered Meals Program		0					17.00
18.00	Homemaker Service		0					18.00
19.00	All Others (specify)		0					19.00
19. 00	Tel emedicine		0					19.00
		400 100	- 1					
20. 00 21. 00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	408, 192 0. 243147	2, 086, 979					20. 00 21. 00
∠1.00	26, line 1 divided by the sum	0. 243147						∠1.00
	of column 26, line 20 minus							
	TOT COLUMN ZO, TITLE ZO MITIUS	1						
	column 26 line 1 rounded to		1				l	
	column 26, line 1, rounded to 6 decimal places.							

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

BASIS HHA CCN: 15-7430

						Home Health	PPS	
		CADITAL DEL	ATED COCTO			Agency I		
		CAPI TAL REL	LATED COSTS					
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
	·	FI XT	EQUI P	BENEFITS	n	E & GENERAL	PLANT	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	FEET)	(GROSS		COST)	FEET)	
		1.00	2.00	SALARIES)	ΕΛ	F 00	7.00	
1. 00	Administrative and General	1.00	2. 00	4. 00 1, 071, 897	5A 0	5. 00 293, 218	7. 00	1. 00
2. 00	Skilled Nursing Care	0	0	1, 071, 077			0	2.00
3. 00	Physical Therapy	l ő	Ö	0	Ö		0	3.00
4.00	Occupational Therapy	0	0	0	0		0	4.00
5.00	Speech Pathology	0	0	0	0	7, 200	0	5.00
6.00	Medical Social Services	0	0	0			0	
7.00	Home Heal th Ai de	0	0	0	_	,	0	7.00
8. 00 9. 00	Supplies (see instructions)	0	0	0	_	_	0	8. 00 9. 00
10.00	Drugs DME		0	0	_	_	0	10.00
11. 00	Home Dialysis Aide Services	0	Ö	0			0	11.00
12.00	Respi ratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0		_	0	14.00
15.00	Health Promotion Activities	0	0	0			0	15.00
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0	0	0	0	0	16. 00 17. 00
18.00	Homemaker Service		0	0		0	0	18.00
	All Others (specify)		0	0	0	0	0	19. 00
19. 50		0	0	0	Ō	0	0	19. 50
20.00	Total (sum of lines 1-19)	0	0	1, 071, 897		1, 692, 883	0	20.00
21. 00		0	0	293, 218		337, 596	0	21.00
22. 00	Unit cost multiplier	0.000000		0. 273551	045575044	0. 199421	0.000000	22. 00
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG (HOURS OF	DI ETARY (PATI ENT	CAFETERIA (FTE'S)	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	
		(POUNDS OF	SERVICE)	DAYS)	(112.3)	N N	SUPPLY	
		LAUNDRY)	02	57.1.0)		(DI RECT	(COSTED	
		,				NRSING HRS)	REQUIS.)	
		8. 00	9. 00	10. 00	11. 00	13. 00	14. 00	
1.00	Administrative and General	0	176	0		_	26, 715	1.00
2. 00 3. 00	Skilled Nursing Care Physical Therapy	0	0	0		_	0	2. 00 3. 00
4. 00	Occupational Therapy		0	0		0	0	4. 00
5. 00	Speech Pathology	l ő	Ö	0	_	Ö	Ö	5. 00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0			0	7. 00
8. 00	Supplies (see instructions)	0	0	0	-	_	0	8.00
9. 00 10. 00	Drugs	0	0	0	_	_	0	9.00
11. 00	DME Home Dialysis Aide Services	0	0	0	0	0	0	10. 00 11. 00
12. 00	Respiratory Therapy		0	0	0	0	0	12.00
13. 00	Private Duty Nursing	0	0	0		0	0	
	Clinic	0	0	0	0	0	0	
15.00	Health Promotion Activities	0	0	0	0	0	0	
16. 00		0	0	0	0	0	0	
17. 00		0	0	0	0	0	0	17.00
18. 00 19. 00	1		0	0			0	18. 00 19. 00
	Tel emedicine		0	0			0	19.00
	Total (sum of lines 1-19)	0	176	0	l ő	o o	26, 715	
21. 00	Total cost to be allocated	0	41, 345	0	Ō	O	•	21.00
22. 00	Unit cost multiplier	0. 000000	234. 914773	0. 000000	0. 000000	0. 000000	0. 204941	22. 00

Health Financial Systems		HENRY (	COUNTY MEMOR	RIAL HOSPIT	AL			In Lieu of Form CMS-2552-10			
ALLOCATION OF GENERAL SERVICE COSTS T	O HHA COST	CENTERS	STATI STI CAI	Provi der	CCN:	15-0030	Peri From	od: 01/01/2017	Worksheet H-2 Part II		
BNOT 3				HHA CCN:		15-7430	То	12/31/2017	Date/Time Pre 5/30/2018 9:1	pared: 3 am	
							Нс	me Health	PPS		
								Agency I			
Cost Center Description	PHARMACY	M	EDI CAL								
	(COSTED	RE	CORDS &								
	REQUIS.)	L	I BRARY								
			(TIME								
		9	SPENT)								

				Agency I	
	Cost Center Description	PHARMACY	MEDI CAL		
		(COSTED	RECORDS &		
		REQUIS.)	LI BRARY		
			(TIME		
			SPENT)		
		15. 00	16. 00		
1.00	Administrative and General	0	21		1.00
2.00	Skilled Nursing Care	0	0		2.00
3.00	Physi cal Therapy	0	0		3.00
4.00	Occupational Therapy	0	0		4.00
5.00	Speech Pathology	0	0		5.00
6.00	Medical Social Services	0	0		6.00
7.00	Home Health Aide	0	0		7.00
8.00	Supplies (see instructions)	0	0		8.00
9.00	Drugs	0	0		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	0	0		19.00
19. 50		0	0		19.50
20.00	Total (sum of lines 1-19)	0	21		20.00
21.00	Total cost to be allocated	0	9, 680		21.00
22.00	Unit cost multiplier	0. 000000	460. 952381		22.00
	•	. '	,		

Heal th	Financial Systems	HE	ENRY COUNTY MEM	IORIAL HOSPITAL	_	In Lie	u of Form CMS-2	2552-10
	IONMENT OF PATIENT SERVICE COS				CN: 15-0030	Peri od:	Worksheet H-3	
				HHA CCN:	15-7430	From 01/01/2017 To 12/31/2017		
				Titl€	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2,	Shared Ancillary Costs (from	Total HHA Costs (cols 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷	
		20,1 20, 11110	Part I)	Part II)	,		col . 4)	
		0	1. 00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF T	HE PROGRAM LI	MITATION COST, (	OR BENEFICIARY	
1.00	Skilled Nursing Care	2.00	1, 262, 578		1, 262, 5	78 4, 546	277. 73	1.00
2. 00	Physical Therapy	3.00						2.00
3.00	Occupational Therapy	4.00						3.00
4.00	Speech Pathology	5.00	10, 736	C	10, 73	36 73	147. 07	4. 00
5.00	Medical Social Services	6. 00	0			0	0.00	1
6.00	Home Health Aide	7.00			56, 1	· ·	38. 35	1
7. 00	Total (sum of lines 1-6)		2, 086, 979	C	2/000//			7. 00
					Program Visi			
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					to Deductibles	Deductibles		
					Coi nsurance			
		0	1. 00	2.00	3. 00	4. 00	5. 00	
	Limitation Cost Computation	1	1	-	1	1		
8.00	Skilled Nursing Care		34620	C	l	24		8.00
8. 01	Skilled Nursing Care		99915 34620					8. 01 9. 00
9. 00 9. 01	Physical Therapy Physical Therapy		99915		1, 9!	19		9.00
10.00	Occupational Therapy		34620			6		10.00
10. 01	Occupational Therapy		99915	ĺ				10.01
11. 00	Speech Pathology		34620	ĺ	1	0		11.00
11. 01	Speech Pathology		99915	C	)	16		11. 01
12.00	Medical Social Services		34620	C		0		12.00
12. 01	Medical Social Services		99915	C	)	0		12. 01
13.00	Home Health Aide		34620	[ C	)	0		13.00
13. 01	Home Heal th Ai de		99915	C		09		13.01
14.00	Total (sum of lines 8-13)  Cost Center Description	From Wkst.	Facility	Shared	4, 95 Total HHA		Datio (col 2	14.00
	cost center bescription	H-2 Part I,	Costs (from	Ancillary	Costs (cols.		Ratio (col. 3 ÷ col. 4)	
		col. 28, line		Costs (from	1 + 2)	Records)	+ (01. 4)	
		20, 11110	Part I)	Part II)	/	110001 40)		
		0	1. 00	2.00	3. 00	4. 00	5. 00	
15 00	Supplies and Drugs Cost Comput						0.000000	1 - 00
	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00				0 0		
10.00	Toose or Brugs	7. 00	Program Visits		Cost of Services		0. 000000	10.00
				t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles & Coinsurance	Coi nsurance		Deductibles & Coinsurance	Coi nsurance	
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	PART I - COMPUTATION OF LESSER COST LIMITATION							
1 00	Cost Per Visit Computation	I -				0 501 011		4
1.00	Skilled Nursing Care	0	_, -,			0 581, 011		1.00
2. 00 3. 00	Physical Therapy Occupational Therapy	0	1, 999 443			0 293, 993 0 65, 152		2. 00 3. 00
3. 00 4. 00	Speech Pathology		16	ł	1	0 65, 152 0 2, 353		4.00
5.00	Medical Social Services		0	<b>l</b>		0 2, 353		5.00
6. 00	Home Heal th Ai de	0	409	<b>l</b>	1	0 15, 685		6.00
7. 00	Total (sum of lines 1-6)	0	4, 959			0 958, 194		7. 00
							'	

	Financial Systems TONMENT OF PATIENT SERVICE COS		NRY COUNTY MEN	Provi der Co	CN: 15-0030 15-7430	Peri od: From 01/01/2017 To 12/31/2017	w of Form CMS-: Worksheet H-3 Part I Date/Time Pre 5/30/2018 9:1	epared:
	Coot Contar Decement on			litle	xVIII	Home Health Agency I	PPS	
	Cost Center Description	6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01 12. 00 12. 01 13. 00 13. 01 14. 00	Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 11. 00 12. 01 13. 00 13. 01 14. 00
		Progr	ram Covered Cha	arges	Cost of Services			
					Jei vi ces			
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Part B  Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
15. 00	Supplies and Drugs Cost Comput Cost of Medical Supplies	ations 0	0	0	1	0 0	0	15.00
	Cost of Drugs		0	l .	1	0	0	1
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE I	PROGRAM COST, A	AGGREGATE OF TI	HE PROGRAM L	IMITATION COST, C	R BENEFICIARY	
1. 00	Cost Per Visit Computation Skilled Nursing Care	581, 011						1.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	293, 993 65, 152 2, 353 0 15, 685 958, 194						2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
	Limitation Cost Computation	12.00						
8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services							8.00 8.01 9.00 9.01 10.00 10.01 11.00 11.01 12.00

Heal th	Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL				In Lieu of Form CMS-2552-10				
APPORTIONMENT OF PATIENT SERVICE COSTS				Provi der C		Period: From 01/01/2017	Worksheet H-3			
				HHA CCN:	15-7430	To 12/31/2017				
				Title	XVIII	Home Health	PPS			
						Agency I				
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to				
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as				
		9, line		provi der	Costs (col.	1 Indicated				
				records)	x col. 2)					
		0	1. 00	2. 00	3. 00	4. 00				
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS										
1.00	Physi cal Therapy	66.00	0. 680976	0		0 col. 2, line 2	. 00	1.00		
2.00	Occupational Therapy	67.00	0. 790465	0	)	0 col. 2, line 3	. 00	2.00		
3.00	Speech Pathology	68. 00	0. 823390	0	1	0 col. 2, line 4	. 00	3.00		
4.00	Cost of Medical Supplies	71.00	0. 182911	0		0 col. 2, line 1	5. 00	4. 00		
5. 00	Cost of Drugs	73. 00	0. 437869	0		0 col. 2, line 1	6. 00	5. 00		

Health Financial Systems HENRY COUNTY MEMO CALCULATION OF HHA REIMBURSEMENT SETTLEMENT			CN: 15-0030	Peri od:		u of Form CMS-2 Worksheet H-4	
		HHA CCN:	15-7430	From 01/01/2 To 12/31/2		Date/Time Pre	
		Title	XVIII	Home Heal		5/30/2018 9:1 PPS	<u>3 ai</u>
				Agency I		t B	
			Part A	Not Subje		Subject to	
				to		Deductibles &	
				Deducti bl e		Coi nsurance	
			1.00	Coi nsuran 2. 00	ice	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUS	TOMARY CHARGE		2.00		0.00	
	Reasonable Cost of Part A & Part B Services						
	Reasonable cost of services (see instructions)			0	0	l .	
	Total charges			0	0	0	2
	Customary Charges  Amount actually collected from patients liable for payment f	or services		0	0	0	3
	on a charge basis (from your records)	01 301 11 003			Ü		`
00	Amount that would have been realized from patients liable fo	r payment		0	0	0	4
	for services on a charge basis had such payment been made in	accordance					
	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0.000	2000	0. 000000	Ę
	Total customary charges (see instructions)		0.0000	0.000	0000	0.000000	1
	Excess of total customary charges over total reasonable cost	(complete		Ö	0	Ō	
	only if line 6 exceeds line 1)						
00	Excess of reasonable cost over customary charges (complete o	nlyifline		0	0	0	8
00	1 exceeds line 6) Primary payer amounts			0	0	0	9
00	Trimary payor amounts			Part A		Part B	
				Servi ce	S	Servi ces	
1	DADT II. COMPUTATION OF HUA DELMBURCEMENT CETTLEMENT			1. 00		2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)				0	0	10
	Total PPS Reimbursement - Full Episodes without Outliers				0	794, 515	
. 00	Total PPS Reimbursement - Full Episodes with Outliers				0	28, 819	12
	Total PPS Reimbursement - LUPA Episodes				0	9, 439	
	Total PPS Reimbursement - PEP Episodes				0	6, 588	
1	Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes	5			0	2, 439 1, 572	
	Total Other Payments				0	0	1
. 00	DME Payments				0	0	18
	Oxygen Payments				0	0	1
	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coin	curanco)			0	0	1 -
	Subtotal (sum of lines 10 thru 20 minus line 21)	sui ance)			0	843, 372	
	Excess reasonable cost (from line 8)				0	0 10, 3,2	
. 00	Subtotal (line 22 minus line 23)				0	843, 372	24
	Coinsurance billed to program patients (from your records)					0	
	Net cost (line 24 minus line 25)				0	843, 372	
	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see	instructions	`				28
	Total costs - current cost reporting period (line 26 plus li		)		0	843, 372	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	27)			0	0.07.072	
. 50	Pioneer ACO demonstration payment adjustment (see instructio	ns)			0	0	
	Demonstration payment adjustment amount before sequestration				0	0	
	Subtotal (see instructions) Sequestration adjustment (see instructions)				0	843, 372	
	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration				0	16, 826 2, 043	
. 01	bemonstration payment adjustment amount after sequestration				0	824, 503	
. 01 . 02	Interim payments (see instructions)						
. 01 . 02 2. 00	Interim payments (see instructions) Tentative settlement (for contractor use only)				0	0	33
1. 01 1. 02 2. 00 3. 00 1. 00	, ,	,			0	0 0	34

Health Financial Systems	AL HOSPITAL	In Lie	u of Form CMS-2552-10	
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS	FOR SERVICES RENDERED	Provider CCN: 15-0030	Peri od:	Worksheet H-5

15-0030 | Peri od: From 01/01/2017 | Date/Time Prepared: 5/30/2018 9:13 am TO PROGRAM BENEFICIARIES HHA CCN:

1.					Home Health	PPS	J dili
mm/dd/yyyy				1. D 1. A		1.0	
1.00			Inpatien	it Part A	Par	T B	
Total Interim payments paid to provider   0   824,503   1.00   2.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interfim payment's payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "MONE" or enter a zero			1. 00	2. 00	3. 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
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero write "NONE" or enter a zero (1)	2. 00				0	0	2. 00
write "NONE" or enter a zero 3. 00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  3. 01 3. 02 3. 03 3. 04 3. 05 3. 06 3. 06 3. 07 3. 08 3. 09 3. 00 3. 0							
List separately each retroactive Lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider		1 91					
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  3.01 3.02 3.03 3.04 3.05 Provider to Program  3.50 3.51 3.52 3.53 3.54 3.53 3.54 3.54 3.99 3.50-3.99) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wist. H-4, Part II), column as appropriate, line 32) 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  5.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER  Contractor Number (Mo/Day/Yrr) 1.00 List Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yrr) 1.00 Contractor Number (Mo/Day/Yrr)	3. 00						3.00
Dayment. If none, write "NONE" or enter a zero. (1)   Program to Provider	0.00						0.00
Program to Provider		for the cost reporting period. Also show date of each					
3.01							
3.02   0		Program to Provider		1			
3.03   0   0   0   0   3.03   3.04   3.05   0   0   0   0   3.05   3.0					~		
3.04   0   0   0   3.04   3.05   7   7   7   7   7   7   7   7   7							
3.05   Provider to Program							
Provider to Program							
3.51   0	0.00	Provider to Program			<u> </u>		0.00
3.52   3.53   3.54   3.99   3.50	3.50	J			0	0	3.50
3.53   0							
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Contractor NPR Date (Mo/Day/Yrr)   Contr					-	_	
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   0   3.99   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   0   824,503   4.00   (transfer to Wkst. H-4, Part II, column as appropriate, line 32)   TO BE COMPLETED BY CONTRACTOR					~		
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)   To BE COMPLETED BY CONTRACTOR		Subtatal (sum of lines 2.01.2.40 minus sum of lines		•			
A.00   Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)   TO BE COMPLETED BY CONTRACTOR	3. 99				0	ا	3. 99
Ctransfer to Wkst. H-4, Part II, column as appropriate, line 32)   TO BE COMPLETED BY CONTRACTOR	4 00				n	824 503	4 00
TO BE COMPLETED BY CONTRACTOR   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   O	00					02.7,000	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   0							
Write "NONE" or enter a zero. (1)   Program to Provider	5. 00						5. 00
Program to Provider							
S. 01   S. 02   S. 03   S. 04   S. 05   S. 0							
5. 02	5. 01	1 rogram to 1 rovi dei			0	0	5. 01
Provider to Program							5. 02
5.50   0	5.03				0	0	5.03
5.51   0		Provider to Program		1			
5.52   0 0 0 5.52							
5. 99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.99         6. 00       Determined net settlement amount (balance due) based on the cost report. (1)       6.01       SETTLEMENT TO PROVI DER       0       2,043       6.01         6. 02       SETTLEMENT TO PROGRAM       0       2,043       6.01         7. 00       Total Medicare program liability (see instructions)       0       826,546       7.00         Contractor Number (Mo/Day/Yr)         0       1.00       2.00							
5.50-5.98   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   6.01   SETTLEMENT TO PROVIDER   0   2,043   6.01   6.02   SETTLEMENT TO PROGRAM   0   0   6.02   7.00   Total Medicare program liability (see instructions)   0   826,546   7.00		Subtotal (sum of lines 5.01-5.49 minus sum of lines			~		
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVI DER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00	5. 77					"	5. 77
the cost report. (1)  SETTLEMENT TO PROVIDER  6.01 SETTLEMENT TO PROGRAM  7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00	6.00	1					6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  0 0 0 6.02 826,546 7.00  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00		the cost report. (1)					
7.00 Total Medicare program liability (see instructions)  0 826,546 7.00  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00				•			
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00						·	
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	lotal Medicare program Hability (see instructions)			_		7.00
0 1.00 2.00							
			(	)			
	8. 00	Name of Contractor					8. 00

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68.00

\* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

NONREI MBURSABLE COST CENTERS

HOSPICE/PALLIATIVE MEDICINE FELLOWS\*

BEREAVEMENT PROGRAM \*

PALLIATIVE CARE PROGRAM\*

OTHER PHYSICIAN SERVICES\*

TELEHEALTH/TELEMONI TORI NG\*

71.00 OTHER NONREIMBURSABLE (SPECIFY)\*

NURSING FACILITY ROOM & BOARD\*

VOLUNTEER PROGRAM \*

RESIDENTIAL CARE\*

FUNDRAI SI NG\*

ADVERTI SI NG\*

THRIFT STORE\*

60.00

61.00

62.00

63.00

64.00

65.00

66.00

67 00

68.00

69 00

70.00

100.00 TOTAL

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1. 00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	l .	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	6, 200		3. 00
4.00	ADMINISTRATIVE & GENERAL*	-10, 366	302, 038		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	43, 931		5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0	l .	6. 00
7.00	HOUSEKEEPI NG*	0	0		7.00
8.00	DI ETARY*	0	0		8. 00
9.00	NURSI NG ADMI NI STRATI ON*	0	0		9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	·	10.00
11. 00	MEDI CAL RECORDS*	0	0		11. 00
12.00	STAFF TRANSPORTATION*	0	0	·	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	29, 152		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15. 00
16.00	OTHER GENERAL SERVI CE*	0	0		16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	I NPATI ENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	23, 500		26. 00
27.00	NURSE PRACTITIONER**	0	0		27. 00
28.00	REGI STERED NURSE**	0	221, 104		28. 00
29.00	LPN/LVN**	0	0		29. 00
30.00	PHYSI CAL THERAPY**	0	0		30.00
31.00	OCCUPATI ONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	38, 929		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DI ETARY COUNSELI NG**	0	0		35. 00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	23, 879		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38. 00
39.00	PATI ENT TRANSPORTATION**	O	0		39.00
40.00	I MAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42. 50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLI ATI VE CHEMOTHERAPY**	0	0		45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY) **	0	0		46. 00
	NONREI MBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAI SI NG*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESI DENTI AL CARE*	0	0		66.00
67.00	ADVERTI SI NG*	0	0		67.00
68.00	TELEHEALTH/TELEMONI TORI NG*	0	0		68.00
69.00	THRI FT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	-10, 366	688, 733		100.00
	ofor the amounts in column 7 to What O.E. or				

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Heal th	Financial Systems HE	ENRY COUNTY MEMOR	RIAL HOSPITAL		In lie	u of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC		Provi der CC	N: 15-0030	Peri od:	Worksheet 0-2	
CARE	TO ST THE STOCK THE STOCK TO THE STOCK THE STO				From 01/01/2017	nor noncot o 2	
			Hospi ce CCN	: 15-1564	To 12/31/2017	Date/Time Pre	
						5/30/2018 9:1	3 am
		CALADIEC	OTUED	CUDTOTAL	Hospi ce I	CURTOTAL	
		SALARI ES	OTHER	SUBTOTAL	RECLASSIFI -	SUBTOTAL	
				(col . 1 +	CATIONS		
		1. 00	2.00	col. 2) 3.00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
25. 00	INPATIENT CARE-CONTRACTED						25. 00
26. 00	PHYSI CLAN SERVI CES	23, 163	0	23, 10	.2	23, 163	
27. 00	NURSE PRACTITIONER	23, 103	0	23, 10	0	23, 103	27.00
28. 00	REGISTERED NURSE	217, 926	0	217, 92	0	217, 926	
29. 00	LPN/LVN	217, 720	0	217, 72	0	217, 720	29.00
30.00	PHYSI CAL THERAPY		0			0	30.00
31. 00	OCCUPATIONAL THERAPY		0			0	31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY		0			0	32.00
33. 00	MEDICAL SOCIAL SERVICES	38, 370	0	38, 3	70	38, 370	33.00
34. 00	SPIRITUAL COUNSELING	30, 370	0	30, 3		0.570	34.00
35. 00	DI ETARY COUNSELI NG	0	0			0	35.00
36. 00	COUNSELING - OTHER	0	0			0	36.00
37. 00	HOSPICE ALDE & HOMEMAKER SERVICES	23, 536	0	23, 53	36	23, 536	
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN	0	0	2070	0	0	38.00
39. 00	PATIENT TRANSPORTATION	0	0		0	0	39.00
40. 00	I MAGING SERVICES	0	0		0	0	40.00
41. 00	LABS & DI AGNOSTI CS	o	o		o o	0	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE	l	ol		ol ol	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	l	ol		ol ol	0	42. 50
43.00	OUTPATI ENT SERVI CES	0	0		ol o	0	43.00
44. 00	PALLIATIVE RADIATION THERAPY	0	0		ol o	0	44.00
45 00	DALLIATIVE CHEMOTHEDADY	1				0	45 00

0 0 0

0 45.00 46.00

302, 995 100. 00

45.00 PALLIATIVE CHEMOTHERAPY
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
	1	6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	I NPATI ENT CARE-CONTRACTED			25.00
26. 00	PHYSI CI AN SERVI CES	0	23, 163	26. 00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	217, 926	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	38, 370	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	23, 536	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	302, 995	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

<sup>100.00</sup> TOTAL \*  $^{\star}$  Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI	CE INDATIENT	Provi der CCI	V: 15_0030	Peri od:	Worksheet 0-3	!
RESPITE CARE	CL INIAIILNI	Trovider co	v. 13-0030	From 01/01/2017	Worksheet 0-3	
NEOT TE OTHE		Hospi ce CCN	15-1564	To 12/31/2017	Date/Time Pre	
				11	5/30/2018 9:1	3 am
	CALABLEC	OTHER	CURTOTAL	Hospi ce I	CURTOTAL	
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI - CATI ONS	SUBTOTAL	
			(col . 1 + col . 2)	CATTONS		
	1. 00	2.00	3.00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
25. 00 I NPATI ENT CARE-CONTRACTED		0		0 0	0	25. 00
26. 00 PHYSI CI AN SERVI CES	213	ol	21	3 0	213	
27. 00 NURSE PRACTITIONER	O	0		0 0	0	27. 00
28. 00 REGI STERED NURSE	2,007	0	2, 00	0	2, 007	28.00
29. 00 LPN/LVN	0	О		0	0	29.00
30. 00 PHYSI CAL THERAPY	0	o		0	0	30.00
31. 00 OCCUPATI ONAL THERAPY	0	0		0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	353	0	35	0	353	33.00
34. 00   SPIRITUAL COUNSELING	0	0		0	0	34.00
35. 00 DI ETARY COUNSELI NG	0	0		0	0	35.00
36. 00 COUNSELING - OTHER	0	0		0	0	36.00
37. 00 HOSPICE AIDE & HOMEMAKER SERVICES	217	0	21	7 0	217	37.00
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN	0	0		0	0	38. 00
39. 00 PATIENT TRANSPORTATION	0	0		0	0	39.00
40. 00   I MAGI NG SERVI CES	0	0		0	0	40.00
41. 00 LABS & DI AGNOSTI CS	0	0		0	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0	0	42.00
42. 50 DRUGS CHARGED TO PATIENTS	0	0		0	0	42.50
43. 00 OUTPATIENT SERVICES	0	0		0	0	43.00
44. 00 PALLIATIVE RADIATION THERAPY	0	0		0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY 46.00 OTHER PATIENT CARE SERVICES (SPECIFY)		0			0	45. 00 46. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 100.00 TOTAL *	2, 790	Ψ	2, 79	0 0	0	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSI CI AN SERVI CES	0	213	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	2, 007	28. 00
29.00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	353	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	217	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39. 00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41. 00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44. 00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
45. 00	PALLI ATI VE CHEMOTHERAPY	0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	2, 790	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

Heal th Financia	I Systems HE SPLTAL-BASED HOSPICE COSTS FOR HOSPI(	ENRY COUNTY MEMO	Provi der CO	N: 15-0030	In Lie	u of Form CMS-2 Worksheet 0-4	
INPATIENT CARE	THE BROLD HOST OF GOOTS FOR HOST IN	SE SENERALE	Hospi ce CCN		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 9:1	pared:
					Hospi ce I	3/30/2010 7.1	J alli
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATI ONS		
				col . 2)			
		1. 00	2. 00	3.00	4. 00	5. 00	
	ATIENT CARE SERVICE COST CENTERS						
	T CARE-CONTRACTED		0		0 0	0	25.00
	N SERVICES	124	0	1	24 0	124	26.00
27. 00 NURSE PR	ACTI TI ONER	0	0		0 0	0	27.00
28. 00 REGI STER	ED NURSE	1, 171	0	1, 1	71 0	1, 171	28. 00
29. 00 LPN/LVN		0	0		0 0	0	
30.00 PHYSI CAL	THERAPY	0	0		0 0	0	30.00
31.00 OCCUPATI	ONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/L	ANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33. 00 MEDI CAL	SOCIAL SERVICES	206	0	2	06 0	206	33.00
34.00 SPIRITUA	L COUNSELING	0	0		0 0	0	34.00
35. 00 DI ETARY	COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELI	NG - OTHER	0	0		0 0	0	36.00
37. 00 HOSPI CE	AIDE & HOMEMAKER SERVICES	126	0	1	26 0	126	37.00
38. 00 DURABLE	MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39. 00 PATI ENT	TRANSPORTATI ON	0	0		0 0	0	39.00
40. 00   I MAGI NG	SERVI CES	0	0		0 0	0	40.00
41.00 LABS & D	I AGNOSTI CS	0	0		0 0	0	41.00
42. 00 MEDI CAL	SUPPLI ES-NON-ROUTI NE	0	o		0 0	0	42.00
42.50 DRUGS CH	ARGED TO PATIENTS	0	o		0 0	0	42.50
43. 00 OUTPATI E	NT SERVICES	O	o		0 0	0	43.00
44. 00 PALLI ATI	VE RADIATION THERAPY	0	ol		0 0	0	44.00
45. 00 PALLI ATI	VE CHEMOTHERAPY	0	o		0 0	0	45.00
46.00 OTHER PA	TIENT CARE SERVICES (SPECIFY)	0	o		0 0	0	46.00
100.00 TOTAL *	, ,	1, 627	ol	1, 6	27 0	1, 627	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5	
		6. 00	± col . 6) 7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25. 00	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	124	26.00
27. 00	NURSE PRACTITIONER		0	27. 00
28. 00	REGI STERED NURSE	0	1, 171	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	o	30.00
31. 00	OCCUPATI ONAL THERAPY	0	o	31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	o	32.00
33.00	MEDICAL SOCIAL SERVICES	0	206	33.00
34.00	SPIRITUAL COUNSELING	0	o	34.00
35.00	DI ETARY COUNSELING	0	o	35.00
36.00	COUNSELING - OTHER	0	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	126	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39. 00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	1, 627	 100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

	Financial Systems HENRY COUNTY MEM				u of Form CMS-2	
	ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der C		Period: From 01/01/2017	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION	Hospi ce CCN: 15-1564		To 12/31/2017	Date/Time Prepared 5/30/2018 9:13 am	
				Hospi ce I		
	Descriptions		HOSPI CE	GENERAL	TOTAL	
			DI RECT	SERVI CE	EXPENSES (sum	
				EXPENSES FROM	of cols. 1 +	
			instructions,	WKST B PART I	2)	
				(see		
			1.00	instructions) 2.00	3. 00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	3.00	
1. 00	CAP REL COSTS-BLDG & FLXT			ol o	0	1.00
2. 00	CAP REL COSTS-MVBLE EQUIP		1	0 0	0	2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT		6, 20	-	109, 371	3.00
4. 00	ADMINISTRATIVE & GENERAL		302, 03		459, 960	4.00
5. 00	PLANT OPERATION & MAINTENANCE		43, 93		43, 931	5.00
6. 00	LAUNDRY & LINEN SERVICE		1	o o	0	6.00
7. 00	HOUSEKEEPI NG		1	o o	0	7.00
8.00	DI ETARY			0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON			0 0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES			0 4, 544	4, 544	10.00
11.00	MEDI CAL RECORDS			0 6, 914	6, 914	11.00
12.00	STAFF TRANSPORTATION			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00	PHARMACY		29, 15	2 0	29, 152	14.00
15. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES			0	0	15.00
16. 00	OTHER GENERAL SERVICE			0		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	17. 00
	LEVEL OF CARE		T	_1	Γ _	
50.00	HOSPI CE CONTI NUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		302, 99		302, 995	
52.00	HOSPICE INPATIENT RESPITE CARE		2, 79		2, 790	ł
53. 00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS		1, 62	/	1, 627	53.00
60.00	BEREAVEMENT PROGRAM			ol	0	60.00
61. 00	VOLUNTEER PROGRAM		1	0	0	61.00
62.00	FUNDRAI SI NG		1	0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM		1	0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES			0		65.00
66. 00	RESI DENTI AL CARE		1	0	0	66.00
67 00				0	0	•

0 0

0 70.00

0 71.00

0 99.00 961, 284 100.00

67.00

68. 00 69. 00

272, 551

688, 733

67. 00 ADVERTISING

68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THRI FT STORE

70.00 NURSING FACILITY ROOM & BOARD
71.00 OTHER NONREIMBURSABLE (SPECIFY)
99.00 NEGATIVE COST CENTER
100.00 TOTAL

COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVI CE COSTS	Provi der C	CN: 15-0030	Peri od:	Worksheet 0-6	
			Hospi ce CCI	N: 15-1564	From 01/01/2017 To 12/31/2017	Part     Date/Time Pre	pared.
			nospi ce coi	10 1001		5/30/2018 9: 1	
					Hospi ce I		
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBL	E EMPLOYEE	SUBTOTAL	
		EXPENSES	& FIX	EQUI P	BENEFI TS		
					DEPARTMENT		
	I	0	1. 00	2. 00	3. 00	3A	
4 00	GENERAL SERVICE COST CENTERS			ı			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0		2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	109, 371	0		0 109, 371		3.00
4. 00	ADMI NI STRATI VE & GENERAL	459, 960	0		0 0	459, 960	4.00
5. 00	PLANT OPERATION & MAINTENANCE	43, 931	0		0 0	43, 931	5. 00
6. 00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6. 00
7. 00	HOUSEKEEPI NG	0	0		0	0	7. 00
8.00	DI ETARY	0	0		0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON	0	0		0	0	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	4, 544	0		0	4, 544	10.00
11. 00	MEDI CAL RECORDS	6, 914	0		0	6, 914	11. 00
12.00	STAFF TRANSPORTATION	0	0		0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.00
14.00	PHARMACY	29, 152	0		0 0	29, 152	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0		0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	302, 995			107, 799	410, 794	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2, 790	0		0 993	3, 783	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1, 627	0		0 579	2, 206	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	o	0		0 0	0	61.00
62.00	FUNDRAI SI NG	o	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	o	0		0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	o	0		0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	o	0		0 0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	o	0		0 0	0	68.00
69.00	THRI FT STORE	o	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	o				0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	o	0		0 0	0	71.00
99. 00	NEGATI VE COST CENTER	o	0		0 0		99.00
100.00	TOTAL	961, 284	0		0 109, 371	961, 284	100.00
	1	' '		•			

Health FinancialSystemsHENRY COUNTY MCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERALSERVICE COSTS Peri od: Worksheet 0-6 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 9:13 am Provider CCN: 15-0030 Hospi ce CCN: 15-1564

						3/30/2010 7.	. 13 aiii
					Hospi ce I		
	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	OPERATION &	LINEN SERVICE			
			MAI NTENANCE				
		4. 00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	•		•			
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	459, 960					4.00
5. 00	PLANT OPERATION & MAINTENANCE	40, 306	84, 237	,			5.00
6. 00	LAUNDRY & LINEN SERVICE	0	0.7.20	1			6.00
7. 00	HOUSEKEEPI NG	0	Č		1		7. 00
8. 00	DIETARY	0	Č		0		0 8.00
9. 00	NURSI NG ADMI NI STRATI ON	0	Č		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	4, 169	Č		0		10.00
11. 00	MEDICAL RECORDS	6, 344			0		11.00
12. 00	STAFF TRANSPORTATION	0, 344			0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION				0		13.00
14. 00	PHARMACY	26, 747			0		14.00
	PHYSICIAN ADMINISTRATIVE SERVICES	20, 747			0		15.00
15.00		0		(	0		
16.00	OTHER GENERAL SERVICE	0		(	0		16.00
17. 00		0	L	1	0		17. 00
FO 00	LEVEL OF CARE			1			
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	376, 899	F0 000				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3, 471	53, 203				0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2, 024	31, 034	. C	0		0 53.00
	NONREI MBURSABLE COST CENTERS	_	_		_		
60.00	BEREAVEMENT PROGRAM	0	C	)	0		60.00
61.00	VOLUNTEER PROGRAM	0	C	)	0		61.00
62.00	FUNDRAI SI NG	0	C	)	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	C	)	0		63.00
64. 00	PALLIATIVE CARE PROGRAM	0	C	)	0		64. 00
65. 00	OTHER PHYSICIAN SERVICES	0	C	)	0		65.00
66. 00	RESI DENTI AL CARE	0	C	)  C	0		0 66.00
67.00	ADVERTI SI NG	0	C	)	0		67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	C	)	0		68.00
69. 00		0	C	)	0		69. 00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	C	) C	0		0 71.00
99. 00	NEGATI VE COST CENTER	0	C	) C	0		0 99.00
100.00	TOTAL	459, 960	84, 237	'  c	0		0 100.00
	,			•	•	•	•

near th	Trilanciai Systems	LINKI COUNTI MEMOI	TIAL HOSH LIAL		III LI C	u or rorm cws	2332-10
COST A	ILLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provi der CC Hospi ce CCN		Peri od: From 01/01/2017 To 12/31/2017		
			nospi ce odi	10 1001	10 12/01/2017	5/30/2018 9: 1	3 am
					Hospi ce I		
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI O	MEDI CAL	RECORDS	TRANSPORTATIO	SERVI CE	
		N	SUPPLI ES		N	COORDI NATI ON	
		9. 00	10. 00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS	7. 00	10.00		12.00	10.00	
1. 00	CAP REL COSTS-BLDG & FLXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7.00
8. 00	DI ETARY						8.00
9. 00	NURSING ADMINISTRATION						9.00
		0	8, 713				1
10.00	ROUTINE MEDICAL SUPPLIES	0	8, /13		-0		10.00
11.00	MEDI CAL RECORDS	0		13, 25	08		11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	1
14.00	PHARMACY	0			0	0	
15. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0			0	0	
16. 00	OTHER GENERAL SERVICE	0			0	0	16. 00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES						17. 00
	LEVEL OF CARE						1
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	
51.00	HOSPICE ROUTINE HOME CARE	0	8, 588			0	
52.00	HOSPICE INPATIENT RESPITE CARE	0	79		20 0	0	
53.00		0	46		70 0	0	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESI DENTI AL CARE	0			0	0	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	o			0	0	71.00
	NEGATI VE COST CENTER	o	0		0 0	0	99.00
100.00		0	8, 713	13, 25	58 0	0	100.00
	1	1	• !	'	!	'	

Health FinancialSystemsHENRY COUNTY MCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERALSERVICE COSTS Peri od: Worksheet 0-6 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 9:13 am Provider CCN: 15-0030 Hospi ce CCN: 15-1564

Hospi ce I	
Descriptions PHARMACY PHYSICIAN OTHER GENERAL PATIENT.	
ADMINISTRATIV SERVICE RESIDENTI	
E SERVI CES CARE SERVI	
14. 00   15. 00   16. 00   17. 00	18. 00
GENERAL SERVICE COST CENTERS	
1.00 CAP REL COSTS-BLDG & FIXT	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT	3.00
4.00 ADMINISTRATIVE & GENERAL	4.00
5.00 PLANT OPERATION & MAINTENANCE	5.00
6.00 LAUNDRY & LINEN SERVICE	6.00
7. 00 HOUSEKEEPI NG	7.00
8. 00 DI ETARY	8.00
9. 00 NURSI NG ADMI NI STRATI ON	9.00
10.00 ROUTINE MEDICAL SUPPLIES	10.00
11. 00 MEDI CAL RECORDS	11.00
12.00 STAFF TRANSPORTATION	12.00
13. 00 VOLUNTEER SERVI CE COORDI NATI ON	13.00
14.00 PHARMACY 55,899	14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0	15.00
16.00 OTHER GENERAL SERVICE 0	16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES	0 17.00
LEVEL OF CARE	
50. 00 HOSPICE CONTINUOUS HOME CARE 0 0 0	0 50.00
51.00 HOSPICE ROUTINE HOME CARE 55,095 0	864, 444 51. 00
52.00 HOSPICE INPATIENT RESPITE CARE 508 0	0 61, 164 52.00
53.00 HOSPICE GENERAL INPATIENT CARE 296 0 0	0 35, 676 53. 00
NONREI MBURSABLE COST CENTERS	
60. 00 BEREAVEMENT PROGRAM 0 0	0 60.00
61.00 VOLUNTEER PROGRAM 0 0	0 61.00
62. 00 FUNDRAI SI NG 0	0 62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0	0 63.00
64.00 PALLIATIVE CARE PROGRAM 0	0 64.00
65. 00 OTHER PHYSICIAN SERVICES 0	0 65.00
66. 00 RESIDENTIAL CARE 0 0 0	0 0 66.00
67. 00 ADVERTI SI NG 0	0 67.00
68. 00 TELEHEALTH/TELEMONI TORI NG 0	0 68.00
69. 00 THRI FT STORE 0	0 69.00
70.00 NURSING FACILITY ROOM & BOARD	0 70.00
71.00 OTHER NONREI MBURSABLE (SPECIFY) 0 0	0 0 71.00
99. 00 NEGATIVE COST CENTER 0 0 0	0 99.00
100. 00 TOTAL 55, 899 0	0 961, 284 100. 00
1 35,57,1 0	751, 251, 100. 00

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVI CE COSTS	Provi der CCN: 15-0030 Hospi ce CCN: 15-1564	Peri od: From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part II Date/Time Prepared: 5/30/2018 9:13 am
				37 307 20 10 9. 13 aiii
			Hospi ce I	
	212 221 2122			

			nospi ce coi	N. 13-1304	10 12/31/2017	5/30/2018 9: 1	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE		ADMI NI STRATI V	
	<b>'</b>	& FIX	EQUI P	BENEFITS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
		(**************************************	VALUE)	(GROSS		COSTS)	
				SALARI ES)			
		1. 00	2.00	3.00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	CAP REL COSTS-BLDG & FLXT	0					1.00
2. 00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	0	0		2		3.00
4. 00	ADMI NI STRATI VE & GENERAL		٥		-459, 960	501, 324	1
5. 00	PLANT OPERATION & MAINTENANCE				107,700	43, 931	5.00
6. 00	LAUNDRY & LINEN SERVICE			]		1 43, 731	
7. 00	HOUSEKEEPI NG			]		0	1
8. 00	DI ETARY		0	]		0	
9. 00	NURSING ADMINISTRATION		0			0	1
10. 00	ROUTINE MEDICAL SUPPLIES		0			4, 544	1
	MEDICAL RECORDS					6, 914	1
12. 00							1
	STAFF TRANSPORTATION		0			0	12.00
	VOLUNTEER SERVICE COORDINATION	0	0	1	0	0	
14.00	PHARMACY	0	0		0	29, 152	1
	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0	0	
	OTHER GENERAL SERVICE	0	_		0	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE	1	1	1		1	
50. 00	HOSPICE CONTINUOUS HOME CARE				0	0	
	HOSPICE ROUTINE HOME CARE			107, 800		,	1
	HOSPICE INPATIENT RESPITE CARE	0				-,	1
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	579	9 0	2, 206	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0	0	00.00
61. 00	VOLUNTEER PROGRAM	0	0	(	0	0	61.00
62.00	FUNDRAI SI NG	0	0		0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0	0	66.00
67.00	ADVERTI SI NG	0	0		0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0	0	68.00
69.00	THRI FT STORE	0	0		0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	1
	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	) 0	0	109, 37	1	459, 960	100.00
	UNIT COST MULTIPLIER	0. 000000	0. 000000			0. 917490	
					1		1

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STATISTICAL BASIS	. SERVICE COSTS	Provider CCN: Hospice CCN:	Peri od: From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part II Date/Time Prepared: 5/30/2018 9:13 am

3171113	TI ONE BROTO		Hospi ce CCI	N: 15-1564 T	o 12/31/2017	Date/Time Pre 5/30/2018 9:1	
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	·	OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMI NI STRATI O	
		MAI NTENANCE	(IN-FACILITY	,	DAYS)	N	
		(SQUARE FEET)	DAYS)		,	(DI RECT NURS.	
			,			HRS. )	
		5. 00	6. 00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	*					
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	84, 136					5.00
6. 00	LAUNDRY & LINEN SERVICE	0	0				6.00
7. 00	HOUSEKEEPI NG	0	_	0			7. 00
8. 00	DI ETARY	0		0	0		8.00
9. 00	NURSING ADMINISTRATION	0		0	, and the second	0	
10.00	ROUTINE MEDICAL SUPPLIES	o o		1 0		0	
11. 00	MEDI CAL RECORDS	0		1 0		0	11.00
12. 00	STAFF TRANSPORTATION	0				o o	12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0				o o	13.00
14. 00	PHARMACY	0				0	14.00
	PHYSICIAN ADMINISTRATIVE SERVICES					0	15. 00
16. 00	OTHER GENERAL SERVICE	0				0	1
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	•			l	17. 00
17.00	LEVEL OF CARE						17.00
50. 00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51. 00	HOSPICE CONTINUOUS HOME CARE					0	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	53, 139	0	0	0	-	1
	HOSPICE GENERAL INPATIENT CARE	30, 997		1			
55.00	NONREI MBURSABLE COST CENTERS	30, 997		<u> </u>		0	33.00
60. 00	BEREAVEMENT PROGRAM	0		1 0		0	60.00
61. 00	VOLUNTEER PROGRAM	0	l .			0	
62. 00	FUNDRAL SI NG					0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS					0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0				0	64.00
65. 00	OTHER PHYSICIAN SERVICES	0				0	65.00
		0	0		0	· ·	1
66. 00	RESI DENTI AL CARE	0	0	0	0	0	66.00
67.00	ADVERTI SI NG	0		0		ľ	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0		0		0	68.00
69.00	THRIFT STORE	0		0		l	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	1 0	0	0	
	NEGATI VE COST CENTER	04.007			_	_	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0 000000	0	0 000000		100.00
101.00	UNIT COST MULTIPLIER	1. 001200	0. 000000	0. 000000	0. 000000	0.000000	1101.00

	Financial Systems LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	HENRY COUNTY MEM	Provi der C		Period:	u of Form CMS-:   Worksheet 0-6	
	STICAL BASIS	SERVICE COSTS	Provider C		From 01/01/2017	Part II	
0.,,,,	THE BASE OF		Hospi ce CC	N: 15-1564	To 12/31/2017	Date/Time Pre 5/30/2018 9:1	pared:
					Hospi ce I	3/30/2016 9. 1	3 alli
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATI (		(CHARGES)	
		SUPPLI ES	(PATI ENT	N	COORDI NATI ON		
		(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS)	11 00	10.00	SERVICE)	14.00	
	CENEDAL SEDVICE COST CENTEDS	10. 00	11. 00	12.00	13.00	14. 00	
1. 00	GENERAL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7.00
8.00	DI ETARY						8. 00
9. 00	NURSI NG ADMI NI STRATI ON						9. 00
10.00	ROUTINE MEDICAL SUPPLIES	5, 288					10.00
11.00	MEDICAL RECORDS		5, 288				11.00
12.00	STAFF TRANSPORTATION				0 0		12.00 13.00
13. 00 14. 00	VOLUNTEER SERVICE COORDINATION PHARMACY				0 0	55, 832	
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES				0 0	00, 632	1
16. 00	OTHER GENERAL SERVICE				0 0	0	1
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES					O	17.00
	LEVEL OF CARE						1
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	5, 212	5, 212		0	55, 029	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	48	48		0	507	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	28	28		0	296	53.00
	NONREI MBURSABLE COST CENTERS			1			
60.00	BEREAVEMENT PROGRAM			•	0	0	
61.00	VOLUNTEER PROGRAM FUNDRALSING				0 0	0	
62. 00 63. 00					0 0	0	62. 00 63. 00
64.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS   PALLIATIVE CARE PROGRAM				0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES				0 0	0	65.00
66. 00	RESI DENTI AL CARE			•	0 0	0	66.00
67. 00	ADVERTI SI NG				0 0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG				0 0	0	68.00
69.00	THRI FT STORE				0 0	0	69.00
70 00	NUDCING FACILITY DOOM & DOADD	1		1		1	70 00

8, 713

1. 647693

13, 258 2. 507186 69. 00 70. 00

71.00

99.00

55, 899 100. 00 1. 001200 101. 00

0

0.000000

0.000000

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD
71. 00 OTHER NONE BURSABLE (SPECIFY)

100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)
101.00 UNIT COST MULTIPLIER

99.00 NEGATIVE COST CENTER

Health Financial Systems	HENRY COUNTY MEMORIAL HOS	PITAL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STATISTICAL BASIS	AL SERVICE COSTS Provid	der CCN: 15-0030	Peri od: From 01/01/2017	Worksheet 0-6 Part II
STATE STORE STORE	Hospi o	ce CCN: 15-1564	To 12/31/2017	Date/Time Prepared:

15-1564 To 5/30/2018 9:13 am Hospi ce I Cost Center Descriptions PHYSI CI AN OTHER GENERAL PATI ENT/ ADMI NI STRATI V SERVI CE RESI DENTI AL E SERVICES (SPECI FY CARE SERVICES (PATIENT BASIS) (IN-FACILITY DAYS) DAYS) 15. 00 16. 00 17.00 GENERAL SERVICE COST CENTERS 1 00 CAP REL COSTS-BLDG & FIXT 1 00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 PLANT OPERATION & MAINTENANCE 5.00 5.00 6.00 LAUNDRY & LINEN SERVICE 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DIFTARY 8.00 NURSING ADMINISTRATION 9.00 9.00 10.00 ROUTINE MEDICAL SUPPLIES 10.00 MEDICAL RECORDS 11.00 11.00 STAFF TRANSPORTATION 12.00 12.00 13.00 VOLUNTEER SERVICE COORDINATION 13.00 PHARMACY 14.00 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 0 15.00 OTHER GENERAL SERVICE 16.00 C 16.00 17.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 0 50.00 0 51.00 HOSPICE ROUTINE HOME CARE 0 51.00 HOSPICE INPATIENT RESPITE CARE 0 52.00 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 53.00 NONREIMBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 60.00 VOLUNTEER PROGRAM 0 61.00 61.00 FUNDRAI SI NG 62.00 62.00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 64.00 PALLIATIVE CARE PROGRAM 64.00 OTHER PHYSICIAN SERVICES 65.00 65.00 66.00 RESIDENTIAL CARE 0 0 66.00 0 67.00 ADVERTI SI NG 0 67.00 68.00 TELEHEALTH/TELEMONI TORI NG 68.00 69.00 THRIFT STORE 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 71.00 99. 00 NEGATI VE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 100.00 101.00 UNIT COST MULTIPLIER 0.000000 0.000000 0.000000 101.00

Health Financial Systems	HENRY COUNTY MEMOR	IAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHA	ARED SERVICE COSTS BY	Provider CCN: 15-0030	Peri od: From 01/01/2017	Worksheet 0-7
LEVEL OF CARE		Hospi ce CCN: 15-1564	To 12/31/2017	Date/Time Prepared:
				5/30/2018 9:13 am

LEVEL OF CARE		Hospi ce CCI	N: 15-1564	Го 12/31/2017	Date/Time Pre 5/30/2018 9:1	
				Hospi ce I		
			Charges by	LOC (from Provi	der Records)	
Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	HCHC	HRHC	HI RC	
	0	1. 00	2.00	3. 00	4. 00	
ANCILLARY SERVICE COST CENTERS						
1. 00 PHYSICAL THERAPY 2. 00 OCCUPATIONAL THERAPY 3. 00 SPEECH PATHOLOGY 4. 00 DRUGS CHARGED TO PATIENTS 5. 00 DURABLE MEDICAL EQUIP-RENTED 6. 00 LABORATORY	66. 00 67. 00 68. 00 73. 00 96. 00 60. 00	0. 790465 0. 823390 0. 437869 0. 245987			0 0 0 0	2.00 3.00 4.00 5.00 6.00
6. 01 BLOOD LABORATORY 7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS 8. 00 OTHER OUTPATIENT SERVICE COST CENTER 9. 00 RADIOLOGY-THERAPEUTIC 10. 00 CARDIAC REHAB 11. 00 Totals (sum of lines 1-11)	60. 01 71. 00 93. 00 55. 00 76. 00			0 0	0	7. 00 8. 00 9. 00
Cost Center Descriptions	Charges by LOC (from Provi der Records) HGI P	HCHC (col. 1 x col. 2) 6.00		HIRC (col. 1 x col. 4) 8.00	HGIP (col. 1 x col. 5) 9.00	
ANCILLARY SERVICE COST CENTERS						
1. 00 PHYSICAL THERAPY 2. 00 OCCUPATIONAL THERAPY 3. 00 SPEECH PATHOLOGY 4. 00 DRUGS CHARGED TO PATIENTS 5. 00 DURABLE MEDICAL EQUIP-RENTED 6. 00 LABORATORY 6. 01 BLOOD LABORATORY 7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS 8. 00 OTHER OUTPATIENT SERVICE COST CENTER 9. 00 RADIOLOGY-THERAPEUTIC	0 0 0 0	0 0 0 0 0			0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 6. 01
10.00 CARDIAC REHAB 11.00 Totals (sum of lines 1-11)	0	0		0 0	0	

Health Financial Systems	HENRY COUNTY MEMOR	IAL HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE	PER DIEM COST	Provi der CCN: 15-0030	Peri od: From 01/01/2017	Worksheet 0-8

Hospi ce CCN: 15-0030 | Peri od: From 01/01/2017 | Provider CCN: 15-1564 | Peri od: From 01/01/2017 | Date/Time Prepared: 5/30/2018 9:13 am

				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	, col . 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	10)	C	0		4.00
5.00	Program cost (line 3 times line 4)	,	C	0		5.00
	HOSPICE ROUTINE HOME CARE					ĺ
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	, col . 7,			864, 444	6.00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				5, 212	7.00
8. 00	Total average cost per diem (line 6 divided by line 7)				165. 86	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 11)	4, 897	0		9.00
10.00	Program cost (line 8 times line 9)		812, 216	0		10.00
	HOSPICE INPATIENT RESPITE CARE					[
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7,	, col . 8,			61, 164	11.00
	line 11)					
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				48	12.00
13.00	Total average cost per diem (line 11 divided by line 12)				1, 274. 25	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 12)	48	0		14.00
15.00	Program cost (line 13 times line 14)		61, 164	0		15.00
	HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7,	, col . 9,			35, 676	16.00
	line 11)					
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				28	17.00
	Total average cost per diem (line 16 divided by line 17)				1, 274. 14	
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 13)	24	0		19.00
	Program cost (line 18 times line 19)		30, 579	0		20.00
	TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				961, 284	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				5, 288	22.00
	Average cost per diem (line 21 divided by line 22)				181. 79	23.00

	Financial Systems HENRY COUNTY MEI ATION OF CAPITAL PAYMENT		Peri od:	u of Form CMS-2	2552-1
CALCUI	ATTON OF CAPITAL PAYMENT	Provider CCN: 15-0030	From 01/01/2017	Worksheet L Parts I-III	
			To 12/31/2017	Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/30/2018 9: 1 PPS	<u>3 am</u>
		TI LIE AVIII	Hospi tai	FF3	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			695, 890	1
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2. 00	Capital DRG outlier payments			286	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost	t reporting period (see ins	structions)	21. 72	
1.00	Number of interns & residents (see instructions) Indirect medical education percentage (see instructions)			0. 00 0. 00	
5. 00 5. 00	Indirect medical education percentage (see instructions)	the sum of lines 1 and 1 C	11 columns 1 and	0.00	
3. 00	1.01) (see instructions)	the sum of filles I and I.C	71, COLUMNS I AND	U	0.0
7. 00	Percentage of SSI recipient patient days to Medicare Part	F part A line	0. 00	7.0	
. 00	30) (see instructions)	2, par : 7. 11110	0.00	'''	
3. 00	Percentage of Medicaid patient days to total days (see instructions)				8.0
9. 00	O Sum of Lines 7 and 8				
10. 00	0.00 Allowable disproportionate share percentage (see instructions)				
11. 00	Disproportionate share adjustment (see instructions)			0	1
12. 00	Total prospective capital payments (see instructions)			696, 176	12.0
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1. 00	Program inpatient routine capital cost (see instructions)			0	1.0
2. 00	Program inpatient ancillary capital cost (see instructions	5)		0	I
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	
4. 00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.0
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2. 00	Program inpatient capital costs for extraordinary circumst	tances (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0 00	
l. 00 5. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0.00	
5. 00 5. 00	Percentage adjustment for extraordinary circumstances (see	a instructions)		0. 00	
7. 00	Adjustment to capital minimum payment level for extraordin		v line 6)	0.00	1
7. 00 3. 00	Capital minimum payment level (line 5 plus line 7)	ary or rounstances (Trie 2	X 11110 0)	0	
9. 00	Current year capital payments (from Part I, line 12, as as	oplicable)		0	
	10	·		0	1

0 10.00

0 13.00

0 14.00

0

0 17.00

11.00

12.00 0

15.00 16.00 0

10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)
14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period

11.00 | Carryover of accumulated capital minimum payment level over capital payment (from prior year

Worksheet L, Part III, line 14)

(if line 12 is negative, enter the amount on this line)

17.00 Current year exception offset amount (see instructions)

15.00 Current year allowable operating and capital payment (see instructions)

16.00 Current year operating and capital costs (see instructions)

12.00

	Financial Systems HE BIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 15-0030 I	Peri od:	u of Form CMS-2 Worksheet M-1	
			Component		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 9:1	
-					RHC I	Cost	3 dili
		Compensati on	Other Costs	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
		·		+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1. 00	Physi ci an	1, 071, 337	25, 554	1, 096, 89 <sup>-</sup>		1, 096, 891	
2.00	Physician Assistant	0	0	(	0	0	
3. 00	Nurse Practitioner	501, 591	0	501, 59 <sup>-</sup>		501, 591	
4.00	Visiting Nurse	0	0	(	0	0	
5.00	Other Nurse	399, 258	49	399, 30	7 0	399, 307	5.00
6. 00	Clinical Psychologist	0	0	(	0	0	
7. 00	Clinical Social Worker	30, 447	0	30, 44	7 0	30, 447	
8. 00	Laboratory Techni ci an	0	0	(	0	0	
9. 00	Other Facility Health Care Staff Costs	320, 888	0	320, 88		320, 888	
10.00	Subtotal (sum of lines 1 through 9)	2, 323, 521	25, 603	2, 349, 12		2, 349, 124	
11. 00	Physician Services Under Agreement	0	0	(	0	0	1
12. 00	Physician Supervision Under Agreement	0	0		0	0	
13. 00	Other Costs Under Agreement	0	181	18		181	
14.00	Subtotal (sum of lines 11 through 13)	0	181	18		181	
15.00	Medical Supplies	0	143, 066	143, 06		143, 066	
16.00	Transportation (Health Care Staff)	0	0		0	0	
17.00	Depreciation-Medical Equipment	0	0		0	0	
18.00	Professional Liability Insurance	0	30, 530	30, 530	0	30, 530	
19.00	Other Health Care Costs	0	0	(	J	0	1 . ,
20.00	Allowable GME Costs	0	170 50/	170 50	,	170 50/	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0 222 521	173, 596	173, 590		173, 596	1
22. 00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2, 323, 521	199, 380	2, 522, 90 <sup>-</sup>	0	2, 522, 901	22. 00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00		0	0		0 (	0	23. 00
24. 00	Dental	0	0		0	0	24.00
25. 00	Optometry	0	0		0	0	
25. 00	Tel eheal th	0	0		0	0	25. 00
25. 02	· I	0	0	l i		0	
26. 00	All other nonreimbursable costs	0	0	l i	0	0	26.00
27. 00	Nonal Lowable GME costs	O		·		O	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	(	0	0	1
20.00	through 27)	0		·		O	20.00
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	546, 353	546, 35	3 0	546, 353	29. 00
	Administrative Costs	593, 910					

546, 353 676, 457 1, 222, 810

1, 422, 190

593, 910

593, 910

2, 917, 431

546, 353 1, 270, 367

1, 816, 720

4, 339, 621

546, 353 1, 653, 438 2, 199, 791

4, 722, 692

383, 071

383, 071

383, 071

30.00

31.00

32.00

30.00 Administrative Costs

31.00

32.00

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-0030	Peri od: From 01/01/2017	Worksheet M-1
	Component CCN: 15-8520		Date/Time Prepared: 5/30/2018 9:13 am

Adjustments				Component	CCN: 15-8520	10	12/31/201/	5/30/2018 9:1	
Adjustments							RHC I		J dili
FACILITY HEALTH CARE STAFF COSTS			Adiustments	Net Expenses			1110 1	0031	
All Cocation (col. 5 + col. 6)			riag ao emorreo						
COL   5   COL   6   COL									
FACILITY HEALTH CARE STAFF COSTS									
FACILITY HEALTH CARE STAFF COSTS				,					
FACILITY HEALTH CARE STAFF COSTS   1.00   1.00   Physic ian   1.00   Physic ian   1.00   Physic ian   1.00   Physic ian   1.00   2.00   0.00   Nurse   1.00   0.0			6. 00		1				
2.00       Physician Assistant       0       0       0       3.00         4.00       Visiting Nurse       0       50.1551       3.00         6.00       Visiting Nurse       0       30.00       6.00         6.00       Clinical Psychologist       0       0.00       7.00         8.00       Laboratory Technician       0       30.447       7.00         8.00       Laboratory Technician       0       30.447       7.00         9.00       Other Facility Heal th Care Staff Costs       0       320.888       9.00         11.00       Physician Services Under Agreement       0       0       0       11.00         12.00       Physician Supervision Under Agreement       0       0       0       11.00         13.00       Other Costs Under Agreement       0       0       181       13.00         14.00       Substal (supplies       0       181       13.00         15.00       Medical Supplies       0       181       14.00         16.00       Transportation (Health Care Staff)       0       181       14.00         17.00       Depreciation-Medical Equipment       0       0       0       17.00         18.00 <td>-</td> <td>FACILITY HEALTH CARE STAFF COSTS</td> <td></td> <td></td> <td>'</td> <td></td> <td></td> <td></td> <td></td>	-	FACILITY HEALTH CARE STAFF COSTS			'				
3.00	1.00	Physi ci an	0	1, 096, 891					1.00
4.00	2.00	Physician Assistant	o	0					2.00
4.00	3.00	Nurse Practitioner	O	501, 591					3.00
6.00	4.00	Visiting Nurse	0	0	)				4.00
6.00	5.00	Other Nurse	0	399, 307					5.00
8.00	6.00	Clinical Psychologist	0						6.00
9.00   Other Facility Health Care Staff Costs   0   320,888   9.00   10.00   Subtotal (sum of lines 1 through 9)   0   2,349,124   10.00   10.	7.00	Clinical Social Worker	0	30, 447					7.00
10.00   Subtotal (sum of lines 1 through 9)   0   2,349,124   10.00	8.00	Laboratory Techni ci an	0	0					8.00
11.00   Physician Services Under Agreement   0   0   0   12.00   Physician Supervision Under Agreement   0   0   0   12.00   13.00   14.00	9.00	Other Facility Health Care Staff Costs	0	320, 888					9.00
12.00	10.00	Subtotal (sum of lines 1 through 9)	0	2, 349, 124					10.00
13.00   Other Costs Under Agreement   0   181   13.00     14.00   Subtotal (sum of lines 11 through 13)   0   181   14.00     15.00   Medical Supplies   0   0   143,066   15.00     16.00   Transportation (Heal th Care Staff)   0   0   0     17.00   Depreciation-Medical Equipment   0   0   0     18.00   Professional Liability Insurance   0   30,530   18.00     19.00   Other Heal th Care Costs   0   0   0     19.00   Other Heal th Care Costs   0   0   0     20.00   Allowable GME Costs   20.00     21.00   Subtotal (sum of lines 15 through 20)   0   173,596   21.00     22.00   Total Cost of Heal th Care Services (sum of lines 10   0   2,522,901     10.00   Other Than RHC/FOHC SERVICES   0   0     23.00   Pharmacy   0   0   0     24.00   Dental   0   0   0     25.00   Optometry   0   0   0     25.00   Optometry   0   0   0     25.00   Optometry   0   0   0     25.01   Teleheal th   0   0   0     25.02   Chronic Care Management   0   0   0     25.02   Onall owable GME Costs   0   0     26.00   All other nonreimbursable costs   0   0     27.00   Nonall owable GME Costs   0   0     28.00   Total Nonreimbursable Costs (sum of lines 23   0   0     27.00   Total Nonreimbursable Costs (sum of lines 23   0   0     27.00   Total Nonreimbursable Costs (sum of lines 23   0   0     27.00   Total Sacility Costs   -319,307   227,046   30,00     30.00   Administrative Costs   -233,876   1,419,562   30,00     30.00   Administrative Costs   -233,876   1,419,562   30,00     30.00   Total facility Costs (sum of lines 29 and -553,183   1,646,608   30,00     30.00   Total facility costs (sum of lines 29 and -553,183   4,169,509   32.00	11.00	Physician Services Under Agreement	0	0					11.00
14.00   Subtotal (sum of lines 11 through 13)   0   181   15.00   Medical Supplies   0   143,066   15.00   16.00   Transportation (Health Care Staff)   0   0   16.00   17.00   Depreciation-Medical Equipment   0   0   0   0   17.00   Depreciation-Medical Equipment   0   0   0   0   0   0   0   0   0	12.00	Physician Supervision Under Agreement	0	0	)				12.00
15.00   Medical Supplies	13.00	Other Costs Under Agreement	0	181					13.00
16. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 19	14.00	Subtotal (sum of lines 11 through 13)	0	181					14.00
17. 00   Depreciation-Medical Equipment   0   0   0   17. 00   18. 00   Professional Liability Insurance   0   30,530   18. 00   20. 00   Other Health Care Costs   0   0   0   21. 00   Subtotal (sum of lines 15 through 20)   0   173,596   21. 00   22. 00   Total Cost of Health Care Services (sum of lines 10, 14, and 21)   0   0   0   23. 00   Dental   0   0   0   24. 00   Dental   0   0   0   25. 00   Optometry   0   0   0   25. 00   Optometry   0   0   0   25. 01   Tel eheal th   0   0   0   25. 02   Chronic Care Management   0   0   0   25. 02   26. 00   All other nonreimbursable costs   0   0   27. 00   Nonall owable GME costs (sum of lines 23   0   0   28. 00   Total Nonreimbursable Costs (sum of lines 23   0   0   29. 00   Facility Overhead (sum of lines 29 and   -553, 183   1, 646, 608   30) 32. 00   Total facility costs (sum of lines 22, 28   -553, 183   4, 169, 509   32. 00	15.00	Medical Supplies	0	143, 066					15.00
18.00   Professional Liability Insurance   0   30,530   18.00   19.00   Other Heal th Care Costs   0   0   0   0   0   0   0   0   0	16.00	Transportation (Health Care Staff)	0	0					16.00
19.00   Other Heal th Care Costs   0   0   0   20.00	17.00	Depreciation-Medical Equipment	0	0	)				17.00
20.00 21.00 Subtotal (sum of lines 15 through 20) 0 173,596 21.00 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES  23.00 Pharmacy 0 0 0 24.00 25.00 Optometry 0 0 0 0 25.00 Optometry 0 0 0 0 25.01 Telehealth 0 0 0 0 25.01 Chronic Care Management 0 0 0 0 25.01 Chronic Care Management 0 0 0 0 25.02 Chronic Care Management 0 0 0 0 26.00 All other nonreimbursable costs 0 0 0 0 0 26.00 Pacility Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	18.00	Professional Liability Insurance	0	30, 530					18. 00
21.00   Subtotal (sum of lines 15 through 20)   0   173,596   22.00   Total Cost of Heal th Care Services (sum of lines 10, 14, and 21)   22.00	19.00	Other Health Care Costs	0	0					19. 00
22.00   Total Cost of Health Care Services (sum of lines 10, 14, and 21)   22.00   2,522,901   23.00   24.00   25.00   24.00   25.00   26.00   25.00   25.01   Tel eheal th   25.02   26.00	20.00	Allowable GME Costs							20.00
Lines 10, 14, and 21)   COSTS OTHER THAN RHC/FOHC SERVICES	21.00	Subtotal (sum of lines 15 through 20)	0	173, 596					21.00
COSTS OTHER THAN RHC/FOHC SERVICES   Pharmacy   Dental   O	22.00	Total Cost of Health Care Services (sum of	0	2, 522, 901					22. 00
23.00 Pharmacy									
24.00   Dental									
25. 00 Optometry 0 0 0 0 25. 00 25. 01 Tel eheal th 0 0 0 0 25. 02 Chronic Care Management 0 0 0 0 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 20 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0						
25. 01 Tel eheal th 0 0 0 25. 01 25. 02 Chronic Care Management 0 0 0 26. 00 All other nonreimbursable costs 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		4	0		1				
25. 02 Chronic Care Management 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	_	1				
26.00		4	0						
27. 00   Nonallowable GME costs   27. 00   28. 00     27. 00   28. 00     28. 00     28. 00     28. 00     28. 00     28. 00     28. 00     28. 00     28. 00     28. 00     28. 00     28. 00     28. 00     28. 00     28. 00     29. 00			0	-	1				
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		4	0	0					1
through 27) FACILITY OVERHEAD  29.00 Facility Costs 30.00 Administrative Costs 31.00 Total Facility Overhead (sum of lines 29 and 30)  32.00 Total facility costs (sum of lines 22, 28 -553, 183 4, 169, 509)  32.00 Total facility costs (sum of lines 22, 28 -553, 183 4, 169, 509)  32.00 Total facility costs (sum of lines 22, 28 -553, 183 4, 169, 509)		1							
FACILITY OVERHEAD  29. 00 Facility Costs	28. 00	,	0	0	)				28. 00
29.00 Facility Costs									
30.00 Administrative Costs -233,876 1,419,562 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 -553,183 4,169,509 32.00					1				ļ
31.00 Total Facility Overhead (sum of lines 29 and 30)  32.00 Total facility costs (sum of lines 22, 28 -553, 183 4, 169, 509)  31.00 31.00			·						
30) 32.00 Total facility costs (sum of lines 22, 28 -553, 183 4, 169, 509 32.00					1				
32.00 Total facility costs (sum of lines 22, 28 -553, 183 4, 169, 509 32.00	31.00	,	-553, 183	1, 646, 608					31.00
	20.00	1 - 7	FF0 100	4 4/0 500					00.00
anu 31)	32.00	,	-553, 183	4, 169, 509					32.00
		anu si)	l		I				I

	Financial Systems HE SIS OF HOSPITAL-BASED RHC/FOHC COSTS	NRY COUNTY MEM			In Lie Period:	u of Form CMS-2	
ANALYS	812 OF HOSPITAL-BASED KHC/FORC COSTS		Provi der C		eriod: From 01/01/2017	Worksheet M-1	
			Component		Γο 12/31/2017		
					RHC II	5/30/2018 9:1 Cost	3 alli
		Compensation	Other Costs	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
		·		+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00			1.00	col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	FACILITY HEALTH CARE STAFF COSTS	207, 858	2, 982	210, 84	154 000	E2 0E1	1.00
1. 00 2. 00	Physi ci an Physi ci an Assi stant	207, 858	2, 982	210, 84	-156, 889	53, 951 0	
3. 00	Nurse Practitioner	135, 292	0	135, 29	-105, 446	· ·	3.00
4. 00	Visiting Nurse	133, 272	0	133, 27	105, 440	27, 040	1
5. 00	Other Nurse	61, 734	140	61, 87	-50, 322	11, 552	
6. 00	Clinical Psychologist	0.,,,,,	0	0.707	0 0	0	6.00
7. 00	Clinical Social Worker	5, 463	Ö	5, 46	3 0	5, 463	
8.00	Laboratory Technician	0	0		0	0	8.00
9.00	Other Facility Health Care Staff Costs	69, 526	0	69, 52	-55, 749	13, 777	9.00
10.00	Subtotal (sum of lines 1 through 9)	479, 873	3, 122	482, 99	-368, 406	114, 589	10.00
11. 00	Physician Services Under Agreement	0	0		0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	1	0	0	
13. 00	Other Costs Under Agreement	0	0	1	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	
15.00	Medical Supplies	0	13, 432	13, 43	2 0	13, 432	1
16.00	Transportation (Heal th Care Staff)	0	0		0	0	
17. 00 18. 00	Depreciation-Medical Equipment Professional Liability Insurance	0	0			0	17. 00 18. 00
19. 00	1	0	0			0	
20. 00		0	٥	·		l	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	13, 432	13, 43	0	13, 432	21.00
22. 00	Total Cost of Health Care Services (sum of	479, 873					22.00
22.00	lines 10, 14, and 21)	177,070	10,001	1,0,12	000, 100	120,021	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES		•	•			1
23.00	Pharmacy	0	0		0	0	23. 00
24.00	Dental	0	0		0	0	24.00
25.00	Optometry	0	0		0	0	25. 00
25. 01	Tel eheal th	0	0	1	0	0	25. 01
25. 02		0	0	1	0	0	25. 02
26. 00	All other nonreimbursable costs	0	0	1	0	0	26.00
27. 00	Nonallowable GME costs	_	_			_	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0		1	0	0	28. 00
	through 27)		L		1		+

94, 131

94, 131

574, 004

275, 241 95, 695

370, 936

387, 490

275, 241

189, 826

465, 067

961, 494

-157, 236

-157, 236

-525, 642

275, 241 32, 590

307, 831

435, 852

29.00

30.00

31.00

32.00

FACILITY OVERHEAD
29.00 Facility Costs

31.00

30.00 Administrative Costs

Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu	ı of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-0030	Peri od: From 01/01/2017	Worksheet M-1
	Component CCN: 15-8525		

			Component CCN: I	5-8525	10	12/31/2017	Date/IIME Pre   5/30/2018 9:1	
						RHC II	Cost	i o aiii
		Adjustments	Net Expenses			1	3001	
		riaj ao timorito	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	53, 951					1.00
2.00	Physician Assistant	ol	o					2.00
3.00	Nurse Practitioner	ol	29, 846					3.00
4.00	Visiting Nurse	ol	ol					4.00
5. 00	Other Nurse	ol	11, 552					5.00
6. 00	Clinical Psychologist	o	0					6.00
7. 00	Clinical Social Worker	ol	5, 463					7. 00
8. 00	Laboratory Techni ci an	ol	0					8.00
9. 00	Other Facility Health Care Staff Costs	ol	13, 777					9.00
10.00	Subtotal (sum of lines 1 through 9)	ol	114, 589					10.00
11. 00	Physician Services Under Agreement	ol	0					11.00
12. 00	Physician Supervision Under Agreement	ol	0					12.00
	Other Costs Under Agreement	ol	0					13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0					14. 00
15. 00	Medical Supplies	0	13, 432					15.00
16. 00	Transportation (Health Care Staff)	0	0					16.00
	Depreciation-Medical Equipment	0	Ö					17.00
18. 00		0	0					18.00
	Other Health Care Costs	0	0					19.00
20. 00	Allowable GME Costs	ď	٩					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	13, 432					21.00
22. 00	Total Cost of Health Care Services (sum of	0	128, 021					22.00
22.00	lines 10, 14, and 21)	ď	120, 021					22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23 00	Pharmacy	O	0					23.00
24. 00	Dental	o O	Ö					24.00
25. 00	Optometry	0	0					25.00
25. 01	Tel eheal th	0	0					25. 01
25. 02	· ·	0	0					25. 02
26. 00	All other nonreimbursable costs	0	0					26.00
27. 00	Nonallowable GME costs	ď	٩					27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0					28.00
20.00	through 27)	٩						20.00
	FACILITY OVERHEAD							1
29 00	Facility Costs	-243, 302	31, 939					29.00
30. 00	Administrative Costs	-243, 302 -2, 574	30, 016					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-2, 574 -245, 876	61, 955					31.00
31.00	30)	-243, 070	01, 733					31.00
32. 00	Total facility costs (sum of lines 22, 28	-245, 876	189, 976					32.00
32.00	and 31)	210,070	107, 770					32.00
	13 3.7	ļ	1					1

Heal th	Financial Systems HI	ENRY COUNTY MEM	NORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Period: From 01/01/2017	Worksheet M-2	
			Component	CCN: 15-8520	To 12/31/2017	Date/Time Pre 5/30/2018 9:1	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Positions						
1. 00	Physi ci an	3. 86		4, 20			1.00
2.00	Physici an Assistant	0.00					2.00
3.00	Nurse Practitioner	3. 97					3.00
4. 00	Subtotal (sum of lines 1 through 3)	7. 83			24, 549		
5. 00	Visiting Nurse	0.00				0	5.00
6. 00	Clinical Psychologist	0.00				0	6. 00
7. 00	Clinical Social Worker	0. 40				43	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4	8. 23	17, 301			24, 592	8. 00
	through 7)		,			,	
9.00	Physician Services Under Agreements		0			0	9.00
	· · · · · · · · · · · · · · · · · · ·						
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVICES			
10.00	Total costs of health care services (from Wk					2, 522, 901	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	
12.00	Cost of all services (excluding overhead) (s					2, 522, 901	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		1, 646, 608	1
15. 00	Parent provider overhead allocated to facili	ty (see instru	ctions)			1, 903, 948	
16. 00	Total overhead (sum of lines 14 and 15)					3, 550, 556	ı
17. 00						0	
	Enter the amount from line 16					3, 550, 556	ł
	Overhead applicable to hospital-based RHC/FC					3, 550, 556	ł
20. 00	Total allowable cost of hospital-based RHC/F	FQHC services (	sum of lines 10	0 and 19)		6, 073, 457	20.00

Heal th	Financial Systems HI	ENRY COUNTY MEN	MORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC :	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2017 To 12/31/2017	Date/Time Pre	narad:
			Component	CCN. 15-6525	10 12/31/2017	5/30/2018 9:1	
					RHC II	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col. 3)	col. 4	
	hu ou To AND DDODUGTINU TV	1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						-
1 00	Posi ti ons	0.14	543	4, 20	0 588		1 00
1. 00 2. 00	Physi ci an Physi ci an Assi stant	0. 14					1.00
3.00	Nurse Practitioner	0.00					3.00
4. 00	Subtotal (sum of lines 1 through 3)	0. 23			1, 113	1, 113	
5.00	Visiting Nurse	0.00			1, 113	1, 113	1
6. 00	Clinical Psychologist	0.00				0	
7. 00	Clinical Social Worker	0. 07				77	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	0. 46	942			1, 190	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOCDITAL DAC	ED DUC/EQUE CEI	חעו כבכ		1. 00	
10 00	Total costs of health care services (from Wk			KVICES		128, 021	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,					128, 021	1
12.00	Cost of all services (excluding overhead) (s					128, 021	
13. 00	Ratio of hospital-based RHC/FQHC services (I					1, 000000	
14. 00	Total hospital -based RHC/FQHC overhead - (fr			ine 31)		61, 955	
15. 00							
16.00	Total overhead (sum of lines 14 and 15)	•	,			141, 995	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16					141, 995	
	Overhead applicable to hospital-based RHC/FC					141, 995	
20. 00	Total allowable cost of hospital-based RHC/F	FQHC services (	sum of lines 1	0 and 19)		270, 016	20.00

ALCULATI ON	cial Systems HENRY COUNTY MEMORI OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
ERVI CES	or nermodicement cerreement for noor the shoes that the		From 01/01/2017		
		Component CCN: 15-8520	To 12/31/2017	Date/Time Pre 5/30/2018 9:1	
		Title XVIII	RHC I	Cost	o alli
		11 (10 )		3331	
				1. 00	
	MINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				1
1	Allowable Cost of hospital-based RHC/FQHC Services (fro			6, 073, 457	
	of vaccines and their administration (from Wkst. M-4, li	ne 15)		188, 934	
1	allowable cost excluding vaccine (line 1 minus line 2)			5, 884, 523 24, 592	
1	Visits (from Wkst. M-2, column 5, line 8) cians visits under agreement (from Wkst. M-2, column 5,	line 9)		24, 392	1
1 -	adjusted visits (line 4 plus line 5)	11116 9)		24, 592	
	ted cost per visit (line 3 divided by line 6)			239. 29	
			Calculation		
			Pri or to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1) 1.00	Peri od 2) 2.00	
00 Per v	isit payment limit (from CMS Pub. 100-04, chapter 9, §20	), 6 or your contractor)	0.00	0.00	8
	for Program covered visits (see instructions)	ne e. yeu. eentraeter,	239. 29	239. 29	
	ATION OF SETTLEMENT				
. 00 Progr	am covered visits excluding mental health services (from	contractor records)	0	6, 475	10
.00 Progr	am cost excluding costs for mental health services (line	e 9 x line 10)	0	1, 549, 403	11
1 0	am covered visits for mental health services (from contr	•	0	0	
1 0	am covered cost from mental health services (line 9 x li		0	0	
	adjustment for mental health services (see instructions		0	0	
	ate Medical Education Pass Through Cost (see instruction Program cost (sum of lines 11, 14, and 15, columns 1, 2	*	0	1, 549, 403	15
1	program charges (see instructions) (from contractor's re	•	- I	964, 717	
	program preventive charges (see instructions) (from prov	•		193, 751	
	program preventive costs ((line 16.02/line 16.01) times	•		311, 177	
5. 04 Total	Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		954, 112	16
	es V and XIX see instructions.)				
	program cost (see instructions)		0	1, 265, 289	
	ry payer amounts	(6		0	
3.00 Less: recor	Beneficiary deductible for RHC only (see instructions)	(Trom contractor		45, 586	18
1	us) iciary coinsurance for RHC/FQHC services (see instructio	ons) (from contractor		145, 076	10
recor	· ·	ms) (Trom contractor		143,070	' '
	edicare cost excluding vaccines (see instructions)			1, 265, 289	20
.00 Progr	am cost of vaccines and their administration (from Wkst.	M-4, line 16)		145, 742	21
1	reimbursable Program cost (line 20 plus line 21)			1, 411, 031	
	able bad debts (see instructions)			0	
1 -	ted reimbursable bad debts (see instructions)			0	
	able bad debts for dual eligible beneficiaries (see inst ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	Tuctions)		0	1
	er ACO demonstration payment adjustment (see instruction	15)		0	
	stration payment adjustment amount before sequestration	,		0	
	eimbursable amount (see instructions)			1, 411, 031	
	stration adjustment (see instructions)			28, 221	
	stration payment adjustment amount after sequestration			0	
	im payments			463, 744	
1	tive settlement (for contractor use only)	00 07		0	
1	ce due component/program (line 26 minus lines 26.01, 26.			919, 066	
0.00  Prote	sted amounts (nonallowable cost report items) in accorda	ince wrth CMS Pub. 15-II	,	0	30

Heal th	Financial Systems HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0030	Period: From 01/01/2017	Worksheet M-3	
SERVI (	ES	Component CCN: 15-8525	To 12/31/2017	Date/Time Pre 5/30/2018 9:1	
		Title XVIII	RHC II	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			270, 016	
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		14, 714	2.00
3. 00 4. 00	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8)			255, 302 1, 190	
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
6.00	Total adjusted visits (line 4 plus line 5)			1, 190	
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	214.54	7.00
			Carcuration	OI LIMIT (I)	
			Pri or to Jan.	On or After	
			1 (Rate Period 1)	Jan. 1 (Rate Period 2)	
			1.00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	0.00	0.00	
9. 00	Rate for Program covered visits (see instructions)		214. 54	214. 54	9.00
10. 00	CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from	contractor records)	0	271	10.00
11. 00	Program cost excluding costs for mental health services (line		0	58, 140	1
12.00	Program covered visits for mental health services (from contr	•	0	0	
13.00	Program covered cost from mental health services (line 9 x li		0	0	
14. 00 15. 00	Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instruction	•	0	0	14.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	58, 140	
16. 01	Total program charges (see instructions)(from contractor's re	•		0	1
16. 02	Total program preventive charges (see instructions) (from prov	•		0	
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0			0 45, 308	
10.04	(Titles V and XIX see instructions.)	and roy trines . ooy		43, 300	10.04
16. 05	Total program cost (see instructions)		0	45, 308	
17.00	Primary payer amounts	(6		0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		1, 505	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		6, 631	19. 00
20.00	Net Medicare cost excluding vaccines (see instructions)			45, 308	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		11, 573	
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			56, 881 0	1
23. 00	Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		Ö	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
25. 50	Prioneer ACO demonstration payment adjustment (see instruction	is)		0	
26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 56, 881	1
26. 01	Sequestration adjustment (see instructions)			1, 138	1
26. 02	Demonstration payment adjustment amount after sequestration			0	
	Interim payments Tentative settlement (for contractor use only)			15, 400	1
28. 00 29. 00	,	02 27 and 28)		0 40, 343	
30.00			,	40, 343	
	chapter I, §115.2				l

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL			u of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHO	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-0030	Peri od:	Worksheet M-4	
VACCINE COST		Component CCN: 15-8520	From 01/01/2017		nared:
		Component CCN. 15-8520	10 12/31/2017	5/30/2018 9: 1	
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	

				3/30/2010 9.1.	o alli
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2, 349, 124	2, 349, 124	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff time	0. 001026	0. 002906	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	2, 410	6, 827	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	35, 610	33, 636	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	38, 020	40, 463	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22)	2, 522, 901	2, 522, 901	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		3, 550, 556	3, 550, 556	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 015070	0. 016038	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	53, 507	56, 944	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	91, 527	97, 407	10.00
	lines 5 and 9)				
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	516	1, 462	11.00
12.00			177. 38	66. 63	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	443	1, 008	13.00
	beneficiaries				
14.00	Program cost of pneumococcal and influenza vaccine and its (t	heir) administration	78, 579	67, 163	14.00
	(line 12 x line 13)				
15.00	Total cost of pneumococcal and influenza vaccine and its (the	ir) administration (sum		188, 934	15.00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3	, line 2)			
16.00	Total Program cost of pneumococcal and influenza vaccine and	its (their)		145, 742	16.00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQH	PNEUMOCOCCAL AND INFLUENZA	Provi der CCN: 15-0030	Peri od: From 01/01/2017	Worksheet M-4
VACCINE COST		Component CCN: 15-8525	To 12/31/2017	Date/Time Prepared: 5/30/2018 9:13 am
		Title XVIII	RHC LT	Cost

Title XVIII   RHC   Cost					5/30/2018 9:13	3 am
1.00 Heal th care staff cost (from Wkst. M-1, col. 7, line 10) 1.00 Ratio of pneumococcal and influenza vaccine staff time to total heal th care staff time 1.00 O.003635 2.00 1.00 Pneumococcal and influenza vaccine heal th care staff time to total heal th care staff time 1.00 O.003635 2.00 1.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 1.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 1.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 1.00 Total direct cost of the hospital -based RHC/FUHC (from Worksheet M-1, col. 7, line 22) 1.00 Direct cost of the hospital -based RHC/FUHC (from Worksheet M-1, col. 7, line 22) 1.00 Direct cost of the hospital -based RHC/FUHC (from Worksheet M-1, col. 7, line 22) 1.00 Direct cost of the hospital -based RHC/FUHC (from Worksheet M-1, col. 7, line 22) 1.00 Direct cost of the hospital -based RHC/FUHC (from Worksheet M-1, col. 7, line 22) 1.00 Direct cost of the hospital -based RHC/FUHC (from Worksheet M-1, col. 7, line 22) 1.00 Direct cost of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 1.00 Direct cost of pneumococcal and influenza vaccine (line 7 x line 8) 1.00 Direct cost of pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 1.00 Direct cost of pneumococcal and influenza vaccine injections (from your records) 1.00 Direct cost of pneumococcal and influenza vaccine and its (their) administration 1.00 Direct cost of pneumococcal and influenza vaccine and its (their) administration 1.00 Direct cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 1.00 Direct cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			Title XVIII	RHC II	Cost	
1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 2.00 Ratio of pneumococcal and influenza vaccine staff time to total health care staff time 3.00 Pneumococcal and influenza vaccine health care staff time to total health care staff time 4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 6.00 Total direct cost of the hospital -based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 9.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 9.10 Total number of pneumococcal and influenza vaccine injections (from your records) 9.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11) 9.00 Total number of pneumococcal and influenza vaccine injection (line 10/line 11) 9.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11) 9.00 Number of pneumococcal and influenza vaccine and its (their) administration (sum of line 12 x line 13) 9.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 9.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 9.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 9.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)				Pneumococcal	I nfl uenza	
2.00 Ratio of pneumococcal and influenza vaccine staff time to total health care staff time 3.00 Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) 4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 5.00 Total direct cost of the hospital -based RHC/FOHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 9.00 Total number of pneumococcal and influenza vaccine injections (from your records) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injections administration (sum of beneficiaries 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13) 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their)  17.573 Total cost of pneumococcal and influenza vaccine and its (their)  18.00 Total Program cost of pneumococcal and influenza vaccine and its (their)  19.00 Total Program cost of pneumococcal and influenza vaccine and its (their)  19.00 Total Program cost of pneumococcal and influenza vaccine and its (their)  19.00 Total Program cost of pneumococcal and influenza vaccine and its (their)				1. 00	2. 00	
3.00 Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) 4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 5.00 Total direct cost of the hospital -based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injections administered to Program beneficiaries 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 14.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)	1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		114, 589	114, 589	1.00
4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 6.00 Total direct cost of the hospital-based RHC/FOHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 9.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 9.10 Total number of pneumococcal and influenza vaccine injections (from your records) 9.00 Number of pneumococcal and influenza vaccine injections (from your records) 9.00 Number of pneumococcal and influenza vaccine injections (from your records) 9.00 Number of pneumococcal and influenza vaccine injections (from your records) 9.00 Number of pneumococcal and influenza vaccine injections (from your records) 9.00 Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries 9.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 9.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 9.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	2.00	Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff time	0. 001268	0. 003635	2.00
5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 6.00 Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 9.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injections (from your records) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	145	417	3.00
Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)  7.00 Total overhead (from Wkst. M-2, line 19)  8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)  9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)  10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)  11.00 Total number of pneumococcal and influenza vaccine injections (from your records)  12.00 Cost per pneumococcal and influenza vaccine injections (line 10/line 11)  13.00 Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries  14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	3, 280	3, 134	4.00
Total overhead (from Wkst. M-2, line 19)  8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)  9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)  10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)  11.00 Total number of pneumococcal and influenza vaccine injections (from your records)  12.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11)  13.00 Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries  14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  10.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	3, 425	3, 551	5.00
8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injections (line 10/line 11) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13) 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22)	128, 021	128, 021	6.00
divided by line 6)  9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)  10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)  11.00 Total number of pneumococcal and influenza vaccine injections (from your records)  12.00 Cost per pneumococcal and influenza vaccine injections (line 10/line 11)  13.00 Number of pneumococcal and influenza vaccine injections administered to Program  26 beneficiaries  14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration  (line 12 x line 13)  15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their)  administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	7.00	Total overhead (from Wkst. M-2, line 19)		141, 995	141, 995	7.00
9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 026753	0. 027738	8.00
Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)  Total number of pneumococcal and influenza vaccine injections (from your records)  Cost per pneumococcal and influenza vaccine injection (line 10/line 11)  Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries  14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)  Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)		divided by line 6)				
lines 5 and 9)  11. 00 Total number of pneumococcal and influenza vaccine injections (from your records)  12. 00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11)  13. 00 Number of pneumococcal and influenza vaccine injections administered to Program  26 beneficiaries  14. 00 Program cost of pneumococcal and influenza vaccine and its (their) administration  (line 12 x line 13)  15. 00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16. 00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	3, 799	3, 939	9.00
Total number of pneumococcal and influenza vaccine injections (from your records)  30 86 11.00  12.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11)  30 87.09 12.00  13.00 Number of pneumococcal and influenza vaccine injections administered to Program  26 61 13.00  14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration  (line 12 x line 13)  15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	10.00		administration (sum of	7, 224	7, 490	10.00
12.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11)  13.00 Number of pneumococcal and influenza vaccine injections administered to Program  26 61  13.00 Number of pneumococcal and influenza vaccine injections administered to Program  26 61  13.00 Program cost of pneumococcal and influenza vaccine and its (their) administration  (line 12 x line 13)  15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,		lines 5 and 9)				
13.00 Number of pneumococcal and influenza vaccine injections administered to Program  26 61 13.00 beneficiaries  14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)  15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,						
beneficiaries  14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)  15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	12.00			240. 80	87. 09	12.00
14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13) 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	13.00		istered to Program	26	61	13.00
(line 12 x line 13) 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,						
15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	14. 00		heir) administration	6, 261	5, 312	14.00
of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,						
16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	15. 00				14, 714	15.00
administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,						
	16. 00				11, 573	16. 00
		, , , , , , , , , , , , , , , , , , , ,	amount to Wkst. M-3,			
		line 21)				

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lieu	ı of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 15-0030	Period: From 01/01/2017	Worksheet M-5
	20	Component CCN: 15-8520	To 12/31/2017	Date/Time Prepared: 5/30/2018 9:13 am
			RHC I	Cost

		Component CCN: 15-8520	10 12/31/2017	5/30/2018 9: 13	
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			463, 744	1. C
. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		0	2.0
00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)  Program to Provider				3. (
01	1 rogi am to 1 rovi dei			0	3. (
02					3. (
03					3.
04					3.
05				0	3.
US	Dravi dan ta Dragnam			U	3.
50	Provider to Program			0	3.
51					3.
51 52					
				0	3.
53				0	3.
54		>		0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)	fer to Worksheet M-3, line	9	463, 744	4.
	TO BE COMPLETED BY CONTRACTOR		_T		
00	List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date c	of		5.
	Program to Provider				
01				0	5.
02				0	5.
03				0	5.
	Provider to Program				
50				0	5.
51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)				6.
01	SETTLEMENT TO PROVIDER	, , ,		919, 066	6.
02	SETTLEMENT TO PROGRAM			0	6.
	Total Medicare program liability (see instructions)			1, 382, 810	7.
UU	1, 13 1, 14 1, 15 1		Contractor	NPR Date	
00			CONTRACTOR	I NPK Date I	
00					
00		0	Number 1.00	(Mo/Day/Yr) 2.00	

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR			From 01/01/2017	
			DHC II	Coct

		Component Con. 13-6325	10 12/31/2017	5/30/2018 9: 13	
			RHC II	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
00	Total interim payments paid to hospital-based RHC/FQHC			15, 400	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3
02				0	3
03				0	3
04				0	3
05				0	3
	Provider to Program				
50				0	3
51				0	3
52				0	3
53				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.49			0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line	<b>:</b>	15, 400	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after desi	k review. Also show date o	of		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	5
02				0	5
03				0	5
	Provider to Program				_
50				0	5
51				0	5
52	0.11.1.1. (	00)		0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)			40.010	6
)1	SETTLEMENT TO PROVIDER			40, 343	6
02	SETTLEMENT TO PROGRAM			[ [0]	6
00	Total Medicare program liability (see instructions)		01	55, 743	7
			Contractor	NPR Date	
		0	Number 1.00	(Mo/Day/Yr) 2.00	