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 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0005 Worksheet S Peri od: From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 7/30/2021 3:06 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 7/30/2021 3:06 pm] Manually prepared cost report use only] 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
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[19] 17. Contractor's Vendor Code:
[19] 18. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[19] Contractor use only number of times reopened = 0-9.

PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HENDRICKS REGIONAL HEALTH (15-0005) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

> STANTON RISSER (Si aned) Officer or Administrator of Provider(s)

> > CF0 Title

> > > (Dated when report is electronically signed.)

Date

			Title	XVIII			
Cost Center Description		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	276, 969	-9, 673	0	-586, 834	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
200.00	Total	0	276, 969	-9, 673	0	-586, 834	200. 00

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

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2020 Part I 12/31/2020 Date/Time Prepared: 7/30/2021 3:06 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1000 EAST MAIN STREET 1.00 PO Box: 1.00 State: IN Zip Code: 46122-1409 County: HENDRICKS 2.00 City: DANVILLE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 HENDRICKS REGIONAL 150005 26900 07/01/1966 Ν 3.00 HFAI TH Subprovi der - IPF 4.00 4.00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 11.00 Hospi tal -Based OLTC 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2020 12/31/2020 20.00 9 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N Ν Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N 22.03 Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 23.00 Ν below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d Medi cai d State State HMO days days paid days el i gi bl e Medi cai d Medi cai d paid days unpai d el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 1.024 2.210 999 in-state Medicaid paid days in column 1, in-state

MCRI F32	-	16.	10.	172. 3

Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/30/2021 3:06 pm In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days eligible days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 25.00 If this provider is an IRF, enter the in-state 25, 00 \cap Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the 26. 00 cost reporting period. Enter "1" for urban or "2" for rural. Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37 01 37 01 instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 | Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 'N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν Ν 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 N Ν 48.00 Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA Ν 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 Ν defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, 59.00 Pt. NAHE 413.85 Pass-Through Worksheet A Y/N Line # Oual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/30/2021 3:06 pm Y/N IME Direct GME IME Direct GME 3. 00 1. 00 2.00 4.00 5.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0 00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA \$5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00 Ν Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs in FTEs Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 0.000000 64.00

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

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

Health Financial Systems In Lieu of Form CMS-2552-10 HENDRICKS REGIONAL HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2020 Part I 12/31/2020 Date/Time Prepared: 7/30/2021 3:06 pm Ratio (col. 3/ Program Name Program Code Unwei ghted Unwei ghted Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col. Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

| Program Name | Program Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTES FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

	4)): (See Thisti de ti ons)								
						1 00			
						1. 00	2.00	3.00	
	Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psyc	hiatric Facility (IPF), or does it conta	in an IPF subp	rovi der?	N			70. 00
	Enter "Y" for yes or "N" for no.								
71.00	If line 70 is yes: Column 1: Did t	ne facility have a	n approved GME teachin	g program in t	he most	N	N	0	71. 00
	recent cost report filed on or before	ore November 15, 20	004? Enter "Y" for ye	s or "N" for n	o. (see				
	42 CFR 412.424(d)(1)(iii)(c)) Colu	mn 2: Did this faci	ility train residents	in a new teach	i ng				
	program in accordance with 42 CFR								
	Column 3: If column 2 is Y, indica	peri od.							
	(see instructions)								
	Inpatient Rehabilitation Facility	PPS							
75.00	Is this facility an Inpatient Rehal	oilitation Facility	y (IRF), or does it co	ntain an IRF		N			75. 00
	subprovider? Enter "Y" for yes and	d "N" for no.							
76.00	If line 75 is yes: Column 1: Did t	ne facility have a	n approved GME teachin	g program in t	he most	N	N	0	76. 00
	recent cost reporting period ending	g on or before Nove	ember 15, 2004? Enter	"Y" for yes or	"N" for				
	no. Column 2: Did this facility tr				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 re	eporting period. (see	instructions)					

Long Term Care Rospi Lail PPS 1.00	S-2 Prepared 3:06 pm
No St this a long term care hospital (LTGH)? Enter "Y" for yes and "N" for no. N N Y" Tor yes and "N" for no. N N Y" Tor yes and "N" for no. N N Y" Tor yes and "N" for no. N N Y" Tor yes and "N" for no. N N Y" Tor yes and "N" for no. N N Y" Tor yes and "N" for no. N N N N N N N N N	\dashv
1.00 s this a LTGH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. TETRA Providers. 5.00 An or another state of the provider of the cost reporting period? Enter "Y" for yes or "N" for no. N of this facility establish a new Other subprovider (excluded unit) under 42 CFR Section N or another subprovider (excluded unit) under 42 CFR Section N or another subprovider (excluded unit) under 42 CFR Section N or another subprovider (excluded unit) under 42 CFR Section N or another subprovider N or another su	00.6
5.00 Dis this Facility establish a new hospital under 42 CFR Section \$413.40(F)(1)(1) TERRY Enter "Y" for yes or "N" for no. 9.13.4.40(F)(1)(1)? Enter "Y" for yes and "N" for no. 10.18 this hospital an extended nepplastic disease care hospital classified under section 10.18 this hospital and extended nepplastic disease care hospital classified under section 10.18 this hospital extended nepplastic disease care hospital classified under section 10.18 this hospital related the plant of the plant o	80. C 81. C
1.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section S413.40(7(1)(11)? Enter "" for yes and "N" for no. N N N N N N N N N	85. (
1886(d) (1) (B) (vi)? Enter "Y" for yes or "N" for no. V XIX Title V and XIX Services 1.00 2.00 Title V and XIX Fallents occupying title V and/or XIX through the cost report either in N Y and the XIII SM beat deal certification)? (see N XIX Fallents occupying title XIII SM beat deal certification)? (see N XIX Fallents occupying title XIII SM beat (dual certification)? (see N XIX Fallents occupying title XIII SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM III SM beat (dual certification)? (see N XIX Fallents occupying title XIX III SM III	86. 0
Title V and XIX Services 1.00 2.00	87.
Does thitle V and XIX Services 0.0 Does thitle V and XIX Services 1.0 Does thitle V and Yax Services 1.0 Does thitle V and Yax Services 1.0 Disthis facility have title V and/or XIX Inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 1.0 Is this hospital relaburesed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 2.0 Are title XIX NP patients occupying title XVIII SNP beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 3.0 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "N N N N N N N N N N N N N N N N N N N	
0.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 1.00 Is this hospital relebursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see Instructions) Enter "Y" for yes or "N" for no in the applicable column. 3.00 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. 3.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 3.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 3.01 If line 94 is "Y", enter the reduction percentage in the applicable column. 3.02 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the N N N Supplicable column. 3.03 Does title V or XIX follow Medicare (title XVIII) for the Interns and residents post stepdom adjustments on What. B. Pt. 1, col. 25° Enter "Y" for yes or "N" for no in the XIX teduce and the XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C. Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.02 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N N N Enter title V, and in column 2 for title XIX. 3.03 Does title V or XIX follow Medicare (title XVIII) for a CAH relimbursed 101% of no lumn 1 for title V, and in column 2 for title XIX. 3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH relimbursed 101% of no lumn 1 for title V, and in column 2 for title XIX. 3.05 Does title V or XIX follow Medicare (title XVIII) for a CAH relimbursed for Wkst. D, Y Y Y Column 2 for title XIX. 3.06 Does title V or XIX follow Medicare (title XVIII) for a CAH relimbursed for Wkst. D, Y Y Y Column 2 for title X	
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Coult of the part? Enter "Y" for yes or "N" for no in the applicable column. 10. On Are title XIX NP patients occupying title XVIII SNP beds (dual certification)? (see instructions) Enter "" for yes or "N" for no in the applicable column. 10. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 10. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 10. If line 94 is "", enter the reduction percentage in the applicable column. 10. If line 94 is "", enter the reduction percentage in the applicable column. 10. If line 96 is "", enter the reduction percentage in the applicable column. 10. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wist. B, Pt. I, col. 257 Enter "Y" for yes or "N" for no in column I for title V, and in column 2 for title XVIII) for the reporting of charges on Wist. 10. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wist. 10. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wist. D. Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reliabursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of uncolumn 2 for title XIX. 10. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wist. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10. Does title V or XIX follow Medicare (title XVIII) when cost reimbursement for title V, and in column 2 for title XIX. 10. Does title V or XIX follow Medicare (title XVIII) when cost reimbursement for title V, and in column 2 for tit	90.
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 3.00 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. 3.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 3.00 Does title V or XIX reduce approach the applicable column. 3.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 3.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post y 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 XVIII) for the reporting or charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 2 for title XIX. 3.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89° Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.03 Does title V or XIX follow Medicare (title XVIII) for a calf reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.04 Does title V or XIX follow Medicare (title XVIII) for a Calf reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 47 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.05 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Y Y PS. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.05 Does title V or XIX follow Medicare (title XVIII) when cost reimbursement for I&R training p	91.
instructions) Enter "Y" for yes or "N" for no in the applicable column. 1.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 1.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 1.00 Does title V or XIX reduce applicable column. 1.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 1.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 1.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 1.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post 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. 1.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 1.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89° Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 1.02 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) relimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 1.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) no outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 1.04 Does title V, and in column 2 for title XIX. 1.05 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) no outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 1.05 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (AH) no column 2 for title XIX. 1.06 Does title V or XIX follow Medicare (title XVIII	92.
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1.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 5.00 If I ine 94 is "Y", enter the reduction percentage in the applicable column. 5.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 7.00 If I ine 94 is "W", enter the reduction percentage in the applicable column. 8.01 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 1, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX III for the interns and residents post column 1 for title V, and in column 2 for title XIX III for the interns and residents post itle V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 8.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. 1V, I ine 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a calculation of observation for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a calculation of observation for title V, and in column 2 for title XIX. 8.05 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of no utpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.06 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.06 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 column 2 for title XIX. 8.07 Does title V or XIX follow Medicare (title XVIII) when cost reimbursement for I&R IX IX IX IX IX IX follow Medicare (title XVIII) wh	93.
5.00 Îfline 94 is "y", enter the reduction percentage in the applicable column. 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 7.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post 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. 8.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 6.01 C, Pt. I? Enter "Y" for yes or "N" for no in column 2 for title XIX. 8.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) relmbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.05 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 column 2 for title XIX. 8.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursement for I&R N N N N N N N N N	94.
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3.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post 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. 3.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 1 for title V, and in column 2 for title XIX. 3.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IN? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IN? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.07 Doloes this hospital qualify as a CAH? 3.08 Does title V or XIX follow Medicare (title XVIII) when cost reimbursement for I&R N training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) 3.07 Doloes this hospital qualify as a CAH? 3.08 Does title V or XIX follow Medicare (title XVIII) when cost reimbursement for I&R N Tr	70.
stepdown adjustments on Wkst. B. Pt. 1, col. 252 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "V" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "V" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "V" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "V" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "V" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.05 Doloes this hospital qualify as a CAH? 8.06 Doloes this hospital qualify as a CAH? 8.07 Doloes this hospital qualify as a CAH? 8.08 Doloes this hospital qualify as a CAH? 8.09 Doloes this hospital qualify as a CAH? 8.00 Doloes this hospital qualify as a CAH? 8.00 Doloes this hospital qualify as a CAH? 8.01 Doloes this hospital qualify as a CAH? 8.02 Doloes this hospital qualify as a CAH? 8.03 Doloes this hospital qualify as a CAH? 8.04 Doloes this hospital qualify as a CAH? 8.05 Doloes this hospital qualify as a CAH? 8.06 Doloes this hospital qualify as a CAH? 8.07 Doloes title VIX. 8.08 Doloes this a rural hospital qualify as a CAH? 8.09 Dol	97.
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por year or in for no roll cach therapy.	109.
1.00	
10.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A N Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,	110.

·	AL HEALTH Provider CC		Peri od:	u of Form CMS Worksheet S-	
· · · · · · · · · · · · · · · · · · ·			From 01/01/2020 Fo 12/31/2020	Part Date/Time Pr	repar
			1	7/30/2021 3:	
			1. 00	2.00	-
1.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to coluintegration prong of the FCHIP demo in which this CAH is particular all that apply: "A" for Ambulance services; "B" for addifor tele-health services.	reporting p mn 1 is Y, e cipating in	eriod? Enter nter the column 2.	N		111
		1. 00	2. 00	3. 00	4
2.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting pe Enter "Y" for yes or "N" for no in column 1. If column 1 is "in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	riod? Y", enter	1. 00 N	2.00	3.00	11:
in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) percent cludes	N			011
5.00 Is this facility classified as a referral center? Enter "Y" fo	r yes or	N			110
"N" for no. 7.00 Is this facility legally-required to carry malpractice insuran "Y" for yes or "N" for no.	ce? Enter	Υ			11
3.00 s the malpractice insurance a claims-made or occurrence polic			1		11
if the policy is claim-made. Enter 2 if the policy is occurren	ce.	Premi ums	Losses	Insurance	
8.01List amounts of malpractice premiums and paid losses:		1. 00 604, 54	2.00	3. 00	0 11
rolphot amounts of marpraetres promitant and para resess.		00.70.			
8.02 Are malpractice premiums and paid losses reported in a cost ce	nter other t	han the	1. 00 N	2.00	11
Administrative and General? If yes, submit supporting schedul and amounts contained therein. O OD DO NOT USE THIS LINE O OD Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in C "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	armless prov olumn 1, "Y" ifies for th	ision in ACA for yes or e Outpatient	N	N	119
.00 Did this facility incur and report costs for high cost implant	able devices	charged to	Υ		12
patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defin Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included. Transplant Center Information	ed in §1903(s "Y", enter	w)(3) of the in column 2	Y	5. 00	12
5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, ente in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter	r the certif	ication date cation date cation date	N		12: 12: 12: 12: 12:
in column 1 and termination date, if applicable, in column 2. 3.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 3.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 3.00 If this is a Medicare certified pancreas transplant center, en date in column 1 and termination date, if applicable, in column 1. 3.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 2. 3.00 Removed and reserved 4.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2. 4.11 Providers	ter the cert n 2. enter the ce n 2. the certifi	ification rtification cation date			13 13 13 13 13

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2020 Part I 12/31/2020 Date/Time Prepared: 7/30/2021 3:06 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143. 00 Ci ty: State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00|If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. N 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) Oil f this provider is a CAH and is not a magningful user, does this provider qualify for a hardship 140 M

100. Util till S provider 15 å CARI alid 15 flot å lledil rigjur user, does till S provider quality for a	nai usni p		100.01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N'	"), enter the	0.0	00169.00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170. 00
	1. 00	2.00	
171.00 ffline 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0 171. 00

	Financial Systems HENDRICKS REGINDURGE HENDRICKS REGINDURG REGINDURG HENDRICKS REGINDURG REGINDURG HENDRICKS REGINDURG RE	Provi der C	CN: 15-0005	Peri od:	u of Form CMS- Worksheet S-2	
,		11011461		From 01/01/2020 To 12/31/2020	Part II	
					7/30/2021 3:0	
				Y/N	Date	
	0	1 C 11 NO		1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	itor all NO re	esponses. Enter	r all dates in 1	rhe	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1
_	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions)			
		,	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
	Has the provider terminated participation in the Medicare F		N			2
	yes, enter in column 2 the date of termination and in colum	n 3, "V" for				
	voluntary or "I" for involuntary.					
	Is the provider involved in business transactions, includir		N			3
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provice					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other	er similar				
	relationships? (see instructions)		Y/N	Typo	Date	
			1.00	7ype 2. 00	3. 00	+
Ti	Financial Data and Reports		1.00	2.00	3.00	
	Column 1: Were the financial statements prepared by a Cert	ified Public	Υ	A	05/21/2021	- 4
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f		'	^	03/21/2021	"
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.	iii abi e iii				
	Are the cost report total expenses and total revenues diffe	erent from	N			5
	those on the filed financial statements? If yes, submit rec					-
			•	Y/N	Legal Oper.	
				1. 00	2.00	
,	Approved Educational Activities					
) c	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	N		7 6
	the Legal operator of the program?					
0	Are costs claimed for Allied Health Programs? If "Y" see ir	nstructions.		N		7
0	Were nursing school and/or allied health programs approved	and/or renewed	d during the	N		8
	cost reporting period? If yes, see instructions.					
	Are costs claimed for Interns and Residents in an approved		cal education	N		9
	program in the current cost report? If yes, see instruction					
	Was an approved Intern and Resident GME program initiated o	or renewed in t	the current	N		10
	cost reporting period? If yes, see instructions.	0 D 1				
	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
П	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes	see instruct	ions		Υ	12
	If line 12 is yes, did the provider's bad debt collection p			st renorting	, N	13
	period? If yes, submit copy.	officy change c	diring this co.	st reporting	IN IN	'3
	lf line 12 is yes, were patient deductibles and/or co-payme	ants waived? If	ves see ins	tructions	N	14
	Bed Complement	into war vou. Ti	yes, see 1115	tr do tr ons.		T ''
	Did total beds available change from the prior cost reporti	na period? If	ves. see inst	ructions.	Υ	15
	<u> </u>		rt A		t B	
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
00	Was the cost report prepared using the PS&R Report only?	Υ	04/07/2021	Υ	04/07/2021	16
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
- 1	instructions)					
00	Was the cost report prepared using the PS&R Report for	N		N		17
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
				I NI	1	1 40
00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19
00		N		N		19

Heal th	Financial Systems HENDRICKS REGI	IONAL HEALTH		In Lie	u of Form CMS-	2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	CN: 15-0005	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Pre 7/30/2021 3:0	epared:		
		Descri	pti on	Y/N	Y/N	Jo piii		
		O		1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
	The port data for other. Beser be the other day astiments.	Y/N	Date	Y/N	Date			
21 00	Was the goot report propered only using the provider's	1.00	2. 00	3. 00	4. 00	21 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HO	OSPI TALS)					
	Capital Related Cost							
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to appraisa	als made dur	ing the cost	N	23. 00		
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	porting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see	N	25. 00		
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th	he cost reporti	ng period? I	f yes, see	N	26. 00		
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost reportino	g period? If	yes, submit	N	27. 00		
	copy. Interest Expense							
28. 00	Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	N	28. 00					
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr	N	29. 00					
30. 00	Has existing debt been replaced prior to its scheduled matuinstructions.	N	30. 00					
31. 00	Has debt been recalled before scheduled maturity without is instructions.	N	31. 00					
32. 00								
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competi	tive bidding? If	N	33. 00		
	Provi der-Based Physi ci ans							
34. 00	Are services furnished at the provider facility under an ar	rrangement with	provi der-ba	sed physicians?	N	34. 00		
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi		ts with the	provi der-based	N	35. 00		
	physicians during the cost reporting period? If yes, see in	iisti ucti ons.		Y/N	Date			
				1.00	2. 00			
	Home Office Costs			1. 00	2.00			
36. 00	Were home office costs claimed on the cost report?			N		36.00		
	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the I	home office?			37. 00		
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00		
39. 00	If line 36 is yes, did the provider render services to other see instructions.			, N		39. 00		
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00		
	1.00 2.00							
	Cost Report Preparer Contact Information	1. (Ζ.	00			
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	MI CHAEL		ALESSANDRI NI		41. 00		
42. 00		BLUE & CO., LLO	C			42. 00		
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317. 713. 7959		MALESSANDRI NI @I	BLUEANDCO. COM	43. 00		

Health Financial Systems		HENDRI CKS RE	EGIONAL HEAL	.TH	In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEAL	TH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi	der CCN: 15-0005	riod: om 01/01/2020 12/31/2020	Date/Time Pr	epared:
						7/30/2021 3:	06 pm
				3. 00			
Cost Report Preparei	Contact Information		<u>'</u>				
41.00 Enter the first nam held by the cost re respectively.	e, last name and the t port preparer in colum		DI RECTOR				41. 00
42.00 Enter the employer/preparer.	company name of the co	st report					42. 00
43.00 Enter the telephone	number and email addr columns 1 and 2, respe						43. 00

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: | Part | P

					0 12/31/2020	7/30/2021 3:0	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	35pariant	Line Number	01 5000	Avai I abl e	07117 11041 0		
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	116	42, 456	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 IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		116	42, 456	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	14	5, 124	0.00	0	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	43. 00				0	13. 00
14. 00	Total (see instructions)		130	47, 580	0.00		14. 00
15. 00	CAH visits					0	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	44. 00	0	C		0	
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	00.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	
27. 00	Total (sum of lines 14-26)		130				27. 00
28. 00	Observation Bed Days					0	
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	C	1		32. 00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days						33. 00
	LTCH site neutral days and discharges						33. 00
33.01	Eron Si to neutrar days and di sonal yes	I	I	I	1	I	1 33.01

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3	
From 01/01/2020	Part	
To 12/31/2020	Date/Time Prepared:	7/30/2021 3:06 pm

						7/30/2021 3:0	6 pm
		I/P Days	o/ O/P Visits	/ Trips	Full Time I	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 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	6, 044	994	16, 379			1. 00
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	2, 975	3, 012				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	o	o				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	o	C			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		o	C			6. 00
7.00	Total Adults and Peds. (exclude observation	6, 044	994	16, 379			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	1, 072	0	3, 013			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		0	2, 769			13. 00
14. 00	Total (see instructions)	7, 116	994	22, 161	0.00	1, 760. 36	1
15.00	CAH visits	0	0	C			15. 00
16.00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER				0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	C	0.00	0.00	
20. 00 21. 00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21.00
23. 00	AMBULATORY SURGICAL CENTER (D.P.)						23. 00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)			121			24. 10
25. 00	CMHC - CMHC			121			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	o	C	0.00	0.00	
27. 00	Total (sum of lines 14-26)	_	٦	_	0.00	l	
28. 00	Observation Bed Days		484	3, 333		,	28. 00
29. 00	Ambul ance Trips	o					29. 00
30.00	Employee discount days (see instruction)			C			30.00
31.00	Employee discount days - IRF			C			31. 00
32.00	Labor & delivery days (see instructions)	o	227	531			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
	outpatient days (see instructions)						
	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

				j	To 12/31/2020	Date/Time Prep 7/30/2021 3:00	
		Full Time Equivalents	1	Di sc	harges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13.00	14.00	15. 00	
1. 00 2. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)		(0 1, 808 689		5, 513	1. 00 2. 00
3. 00 4. 00 5. 00 6. 00 7. 00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)				0		3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00 18. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER	0.00	(1, 808	3 171	5, 513	14. 00 15. 00 16. 00 17. 00 18. 00
19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0.00					19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0.00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and discharges			•			33. 00 33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared:

					To	o 12/31/2020	Date/Time Pre 7/30/2021 3:0	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries		Paid Hours Related to	Average Hourly Wage (col. 4 ÷	
				(from Wkst. A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
	PART II - WAGE DATA	1. 00	2.00	3.00	4. 00	5. 00	6. 00	
	SALARI ES							1
1.00	Total salaries (see instructions)	200. 00	158, 595, 237	0	158, 595, 237	3, 661, 553. 45	43. 31	1. 00
2.00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		1, 608, 946	0	1, 608, 946	8, 615. 00	186. 76	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		12, 341, 286	0 0		0. 00 95, 696. 00		
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		C	0	0	0.00	0. 00	6.00
7. 00	services Interns & residents (in an approved program)	21. 00	C	0	0	0.00	0.00	7. 00
7. 01	Contracted interns and residents (in an approved		C	0	0	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		C	0	0	0.00	0.00	8.00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	55, 888, 797	0 -397, 674	0 55, 491, 123	0. 00 1, 003, 409. 91	l .	
	instructions) OTHER WAGES & RELATED COSTS		· · ·					_
11. 00	Contract Labor: Direct Patient Care		704, 560	0	704, 560	12, 376. 02	56. 93	11. 00
12. 00	Contract labor: Top level management and other management and administrative services		C	0	0	0.00	0.00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		612, 540	0	612, 540	3, 015. 00	203. 16	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		C	0	0	0.00	0.00	14.00
14. 01	Home office salaries		C	0	0	0.00	l .	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		C	0	0	0. 00 0. 00	l .	
	- Administrative		_					
16. 00	Home office and Contract Physicians Part A - Teaching		C	0	0	0.00	0.00	16. 00
16. 01	Home office Physicians Part A - Teaching		C	0	0	0.00	0.00	16. 01
16. 02	Physicians Part A - Teaching		C	0	0	0.00	0.00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		22, 601, 312	2 0	22, 601, 312			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		9, 357, 861	0	9, 357, 861 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		C	0	0			21. 00
22. 00	B Physician Part A -		146, 911	0	146, 911			22. 00
22. 01 23. 00	Administrative Physician Part A - Teaching Physician Part B		1, 418, 376	0 0	0 1, 418, 376			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an approved program)		C	0	0			24. 00 25. 00
25. 50	Home office wage-related (core)		C	0	0			25. 50
25. 51	Related organization wage-related (core)		C	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		C	0	0			25. 52

					T	o 12/31/2020	Date/Time Prep 7/30/2021 3:0	
		Wkst. A Line		Recl assi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
	I	1.00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
24 00	OVERHEAD COSTS - DIRECT SALARIE		2 2/0 572	720 207	2 000 000	75 440 74	41.06	24 00
26. 00	Employee Benefits Department	4. 00	2, 368, 573			,		26. 00
27. 00	Administrative & General	5. 00	13, 756, 595					
28. 00	Administrative & General under		2, 744, 999	0	2, 744, 999	34, 743. 50	79. 01	28. 00
29. 00	contract (see inst.)	6. 00	0	_	_	0.00	0.00	29. 00
30.00	Maintenance & Repairs Operation of Plant	7.00	2, 817, 409	-13, 181	2, 804, 228			
31. 00	, ·	7. 00 8. 00	2, 817, 409 379, 002					
31.00	Laundry & Linen Service Housekeeping	9.00	•					
32.00		9.00	2, 771, 632	-12, 967	2, 758, 005	151, 967. 85		
33.00	Housekeeping under contract (see instructions)		Ü	0		0.00	0. 00	33.00
34.00	Di etary	10. 00	2, 025, 938	-1, 309, 490	716, 448	35, 400. 50	20. 24	34.00
35. 00	Di etary under contract (see instructions)		0	0	0	0.00	0. 00	35. 00
36.00	Cafeteri a	11. 00	0	1, 300, 011	1, 300, 011	64, 234. 00	20. 24	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	6, 078, 657	-28, 438	6, 050, 219	135, 820. 03	44. 55	38. 00
39.00	Central Services and Supply	14. 00	1, 133, 650	-5, 304	1, 128, 346	44, 354. 30	25. 44	39. 00
40.00	Pharmacy	15. 00	2, 621, 026	-12, 262	2, 608, 764	59, 054. 65	44. 18	40. 00
41.00	Medical Records & Medical	16. 00	631, 332	20, 992	652, 324	25, 328. 90	25. 75	41.00
	Records Library							
42.00	Social Service	17. 00	1, 966, 041	-9, 198	1, 956, 843	54, 541. 57	35. 88	42.00
43. 00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

						0 12/31/2020	Date/Time Prep 7/30/2021 3:00	
		Worksheet A	Amount	Reclassi fi cati	Adjusted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es		Wage (col. 4 ÷	
			·	(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4	·	
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		148, 998, 950	0	148, 998, 950	3, 600, 600. 95	41. 38	1.00
	instructions)							
2.00	Excluded area salaries (see		55, 888, 797	-397, 674	55, 491, 123	1, 003, 409. 91	55. 30	2.00
	instructions)							
3.00	Subtotal salaries (line 1		93, 110, 153	397, 674	93, 507, 827	2, 597, 191. 04	36. 00	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 317, 100	0	1, 317, 100	15, 391. 02	85. 58	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		22, 748, 223	0	22, 748, 223	0.00	24. 33	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		117, 175, 476	397, 674	117, 573, 150	2, 612, 582. 06	45. 00	6.00
7.00	Total overhead cost (see		39, 294, 854	707, 183	40, 002, 037	1, 151, 134. 79	34. 75	7.00
	instructions)							

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0005	Peri od: Worksheet S-3 From 01/01/2020 Part IV To 12/31/2020 Date/Time Prepared:

	To 12/31/2020	Date/Time Prep 7/30/2021 3:00	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	4, 636, 429	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	823, 432	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	16, 351, 600	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	251, 251	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)	411, 435	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	1, 079, 789	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17. 00		9, 493, 831	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	109, 910	
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
00.00	instructions))	0	00.00
22. 00		0	22. 00
23. 00	Tuition Reimbursement	366, 783	23. 00
24. 00	,	33, 524, 460	24. 00
25 00	Part B - Other than Core Related Cost		25 00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part V Date/Time Pre 7/30/2021 3:00	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1 00	2 00	

			7/30/2021 3:0	6 pm
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	704, 560	33, 524, 460	1.00
2.00	Hospi tal	704, 560	33, 524, 460	2.00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF	0	0	8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18. 00	Other	0	0	18. 00

SPI TAL	UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0005	Period: From 01/0	1/2020	Worksheet S-	10
				1/2020	Date/Time Pro 7/30/2021 3:0	
				_	1. 00	
Ur	ncompensated and indigent care cost computation					
	ost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by line 202 col	umn 8)		0. 284063	3 1
	edicaid (see instructions for each line) let revenue from Medicaid				2 250 044	4 2
4	id you receive DSH or supplemental payments from Medicaid?				3, 250, 846 Y	6 2 3
	fline 3 is yes, does line 2 include all DSH and/or supplement	tal payments from Med	li cai d?		N	4
	fline 4 is no, then enter DSH and/or supplemental payments fr				3, 755, 582	2 5
	ledi cai d charges				71, 263, 643	
	ledicaid cost (line 1 times line 6)	=			20, 243, 364	
	ifference between net revenue and costs for Medicaid program (zero then enter zero)	(line 7 minus sum of	lines 2 and 5);	13, 236, 936	6 8
	hildren's Health Insurance Program (CHIP) (see instructions fo	or each line)				
	et revenue from stand-alone CHIP				(9
00 S	tand-alone CHIP charges				(0 10
	tand-alone CHIP cost (line 1 times line 10)				-	11 כ
	ifference between net revenue and costs for stand-alone CHIP ((line 11 minus line 9); if < zero t	hen	(0 12
	nter zero) ther state or local government indigent care program (see inst	ructions for each li	ne)			
	let revenue from state or local indigent care program (Not incl			Τ	(13
	charges for patients covered under state or local indigent care			or		0 14
10	0)					
	tate or local indigent care program cost (line 1 times line 14					0 15
	ifference between net revenue and costs for state or local inc	digent care program ((line 15 minus	line	(0 16
	3; if < zero then enter zero) rants, donations and total unreimbursed cost for Medicaid, CHI	P and state/Local in	ndigent care r	rogram	IS (SEE	
	nstructions for each line)	. and otato/roodi	iai goire oai o p	og. a	.5 (555	
	rivate grants, donations, or endowment income restricted to fu					17
	overnment grants, appropriations or transfers for support of h			.		18
	otal unreimbursed cost for Medicaid , CHIP and state and local , 12 and 16)	indigent care progi	ams (sum of I	i nes	13, 236, 936	5 19
		Uni nsur	ed Insur	ed	Total (col. 1	
		pati en	ts patie		+ col . 2)	
		1.00	2. 00)	3. 00	
	ncompensated Care (see instructions for each line) Tharity care charges and uninsured discounts for the entire fac	cility 10, 25	1 012 1 7	42, 541	11, 994, 453	3 20
	see instructions)	10, 25	1, 712	+2, 54 1	11, 774, 45	3 20
1 7	ost of patients approved for charity care and uninsured discou	unts (see 2, 91)	2, 189 1, 74	42, 541	4, 654, 730	21
	nstructions)					
	ayments received from patients for amounts previously written	off as	0	0	(0 22
	harity care ost of charity care (line 21 minus line 22)	2 01	2, 189 1, 74	42, 541	4, 654, 730	1 23
00 0	ost of chartty care (fine 21 millius fine 22)	2,712	2, 107 1, 7	+2, 541	4, 054, 750	7 23
					1. 00	
	oes the amount on line 20 column 2, include charges for patier		th of stay li	mi t	N	24
00 1	mposed on patients covered by Medicaid or other indigent care fline 24 is yes, enter the charges for patient days beyond th	program? ne indigent care proq	gram's Length	of	(25
- 1	tay limit				1/ 512 001	
- 1	otal bad debt expense for the entire hospital complex (see ins ledicare reimbursable bad debts for the entire hospital complex	*		}	16, 513, 083 221, 153	
- 1	ledicare allowable bad debts for the entire hospital complex (s	•		-	340, 235	
					16, 172, 848	- 1
	lon-Medicare bad debt expense (see instructions)					
00 N	ion-medicare bad debt expense (see instructions) iost of non-Medicare and non-reimbursable Medicare bad debt exp	oense (see instructio	ons)	İ	4, 713, 190) 29
00 No 00 Co 00 Co	1 ,	·	ons)		4, 713, 190 9, 367, 920 22, 604, 856) 30

Health Financial Systems	HENDRICKS REGIO	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der Co		eri od:	Worksheet A	
				rom 01/01/2020 o 12/31/2020	Date/Time Pre	narod:
			'	o 12/31/2020	7/30/2021 3:0	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00			4 00	col . 4)	
CENEDAL CEDALCE COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT		26, 230, 496	26, 230, 496	ol	26, 230, 496	1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 368, 573	23, 327, 993			26, 536, 115	4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	13, 756, 595	58, 320, 470			72, 236, 133	5. 00
7. 00 00700 OPERATION OF PLANT	2, 817, 409	8, 634, 215			11, 510, 112	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	379, 002	110, 795			509, 118	8. 00
9. 00 00900 HOUSEKEEPI NG	2, 771, 632	877, 567	3, 649, 199	-13, 618	3, 635, 581	9. 00
10. 00 01000 DI ETARY	2, 025, 938	1, 447, 206	3, 473, 144	-2, 242, 510	1, 230, 634	10.00
11. 00 01100 CAFETERI A	0	0	C	_, _, _, ,,	2, 233, 025	11. 00
13. 00 01300 NURSING ADMINISTRATION	6, 078, 657	4, 410, 495			9, 514, 394	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	1, 133, 650	1, 629, 054			2, 735, 791	1
15. 00 01500 PHARMACY	2, 621, 026	11, 558, 029			3, 558, 930	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	631, 332 1, 966, 041	695, 080 224, 448			1, 366, 064 2, 180, 050	16. 00 17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	1, 700, 041	224, 440	2, 170, 407	-10, 437	2, 160, 050	17.00
30. 00 03000 ADULTS & PEDI ATRI CS	18, 413, 952	2, 644, 803	21, 058, 755	-5, 021, 911	16, 036, 844	30.00
31. 00 03100 NTENSI VE CARE UNI T	3, 181, 033	946, 538			4, 035, 562	31.00
43. 00 04300 NURSERY	0	1, 461			1, 647, 566	•
44.00 04400 SKILLED NURSING FACILITY	O	0	C	0	0	44. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 649, 004	8, 970, 017			3, 684, 184	50.00
50. 01 05001 ENDOSCOPY	1, 013, 997	578, 142			1, 518, 298	
51. 00 05100 RECOVERY ROOM	1, 413, 909	294, 952			1, 698, 730	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	36, 815			3, 223, 555	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 825, 136 6, 277, 559	851, 001 2, 119, 906			7, 611, 797 8, 195, 857	53. 00 54. 00
54. 00 05400 RADI 0L0GY	1, 368, 626	15, 330, 660			16, 805, 828	54. 00
56. 00 05600 RADI OI SOTOPE	1, 300, 020	13, 330, 000	10,077,200	0	0 003,020	56.00
56. 01 05601 NUCLEAR MEDICINE	206, 422	224, 916	431, 338	-62, 638	368, 700	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	578, 675	1, 285, 380			1, 586, 958	59. 00
60. 00 06000 LABORATORY	3, 406, 780	6, 658, 638			10, 051, 381	1
64. 00 06400 I NTRAVENOUS THERAPY	1, 009, 688	539, 230	1, 548, 918	82, 735	1, 631, 653	64. 00
65. 00 06500 RESPI RATORY THERAPY	2, 459, 839	720, 153			3, 115, 461	
66. 00 06600 PHYSI CAL THERAPY	6, 094, 051	2, 022, 670			8, 048, 333	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	527, 879	72, 856	1		597, 839	67. 00
68. 00 06800 SPEECH PATHOLOGY	339, 000	28, 122	1		365, 987	1
69. 00 06900 ELECTROCARDI OLOGY	894, 148	286, 524			1, 174, 496	
69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY	558, 293 123, 876	54, 919			609, 695 142, 032	1
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	123, 876	18, 736	142, 612		142, 032	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		_	11, 048, 726	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	0			11, 576, 785	
73. 01 07301 ULTRA SOUND	612, 743	70, 981	683, 724			
74.00 07400 RENAL DIALYSIS	264	329, 212			329, 255	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 565, 656	3, 964, 585			4, 842, 026	90. 00
91. 00 09100 EMERGENCY	6, 636, 055	1, 682, 377	8, 318, 432	-83, 394	8, 235, 038	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
SPECIAL PURPOSE COST CENTERS	100 707 110	407 400 440	000 005 000	0 404 (04	000 007 5//	440.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	102, 706, 440	187, 199, 442	289, 905, 882	2, 431, 684	292, 337, 566] 118. 00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	47, 932, 516	17, 936, 364	65, 868, 880	-2, 368, 918	63, 499, 962	102 00
192. 01 19201 HEALTH TRACKS	3, 181, 617	701, 106			3, 853, 098	•
194. 00 07950 PRI MARY CARE CLINIC	922, 286	1, 376, 467			2, 291, 982	
194. 01 07951 PARTNERS IN CARE	0	-16, 799			-16, 799	
194. 02 07952 OCCUPATI ONAL MEDI CI NE	425, 224	526, 966			949, 834	
194. 03 07953 FOUNDATI ON	150, 394	21, 426			171, 116	
194.04 07954 SCHOOL & TOWN CLINICS	1, 493, 234	775, 715			2, 255, 562	
194.05 07955 MANAGED FACILITY	450, 302	148, 802			596, 995	
194. 06 07956 RENTAL PROPERTI ES	190	164, 046			164, 235	
194. 07 07957 SNF NON CERTIFIED	1, 333, 034	202, 403			1, 527, 624	
200.00 TOTAL (SUM OF LINES 118 through 199)	158, 595, 237	209, 035, 938	367, 631, 175	6 0	367, 631, 175	₁ 200.00

| Period: | Worksheet A | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: 7/30/2021 3:06 pm

				7/30/2021 3:0)6 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation	1	
	1	6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				4
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-555, 189			1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-576, 941			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-19, 754, 788			5. 00
7.00	00700 OPERATION OF PLANT	-157, 887	11, 352, 225		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0			8. 00
9.00	00900 HOUSEKEEPI NG	0			9.00
10.00	01000 DI ETARY	-480, 318			10.00
11. 00	01100 CAFETERI A	-893, 348			11. 00
13. 00	01300 NURSING ADMINISTRATION	-119, 787			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-67, 276	l		14. 00
15. 00	01500 PHARMACY	-46, 365			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-34			16. 00
17. 00	01700 SOCI AL SERVI CE	0	2, 180, 050)	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				4
30. 00	03000 ADULTS & PEDI ATRI CS	-3, 579, 559			30. 00
31. 00	03100 INTENSIVE CARE UNIT	-337, 143			31.00
43. 00	04300 NURSERY	0			43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		44. 00
	ANCI LLARY SERVICE COST CENTERS	T		T	4
50. 00	05000 OPERATING ROOM	-372			50. 00
50. 01	05001 ENDOSCOPY	0			50. 01
51. 00	05100 RECOVERY ROOM	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 223, 555		52. 00
53.00	05300 ANESTHESI OLOGY	-6, 623, 485			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-59, 816		l control of the cont	54.00
54. 01	05401 RADI ATI ON-ONCOLOGY	-17, 850	1	l e e e e e e e e e e e e e e e e e e e	54. 01
56. 00	05600 RADI OI SOTOPE	0			56. 00
56. 01	05601 NUCLEAR MEDICINE	0	368, 700		56. 01
59.00	05900 CARDI AC CATHETERI ZATI ON	0	.,		59. 00
60. 00	06000 LABORATORY	-398, 509			60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	1, 631, 653		64. 00
65. 00	06500 RESPI RATORY THERAPY	0	3, 115, 461		65. 00
66. 00	06600 PHYSI CAL THERAPY	-815, 251	7, 233, 082		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	-78, 857	518, 982		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	365, 987		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-154, 990	1, 019, 506		69. 00
69. 01	06901 CARDI AC REHAB	0	609, 695		69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	142, 032		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11, 576, 785		73. 00
73. 01	07301 ULTRA SOUND	0	678, 537	1	73. 01
74.00		0	329, 255		74. 00
	OUTPATIENT SERVICE COST CENTERS			T	
90.00	09000 CLI NI C	0			90.00
91.00	09100 EMERGENCY	-1, 250, 501	6, 984, 537	1	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-35, 968, 266	256, 369, 300		118. 00
	NONREI MBURSABLE COST CENTERS				
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	63, 499, 962		192. 00
192.01	1 19201 HEALTH TRACKS	0	3, 853, 098	3	192. 01
194.00	07950 PRIMARY CARE CLINIC	0	2, 291, 982	2	194. 00
194.01	07951 PARTNERS IN CARE	0	-16, 799)	194. 01
194. 02	07952 OCCUPATIONAL MEDICINE	0	949, 834	·	194. 02
	B 07953 FOUNDATI ON	0	171, 116)	194. 03
194. 04	4 07954 SCHOOL & TOWN CLINICS	0	2, 255, 562	2	194. 04
	07955 MANAGED FACILITY	0	596, 995	5	194. 05
	07956 RENTAL PROPERTIES	0	164, 235		194. 06
	7 07957 SNF NON CERTIFIED	0	l		194. 07
200.00		-35, 968, 266	l		200. 00
			•	•	•

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/30/2021 3:06 pm Provider CCN: 15-0005

					7/30/2	021 3:06 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4.00	5.00		
	A - DRUGS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	79, 104		1. 00
2.00	I NTRAVENOUS THERAPY	64.00	o	93, 554		2. 00
3.00	DRUGS CHARGED TO PATIENTS	73. 00	ol	11, 576, 785		3. 00
4.00		0.00	o	0		4. 00
5. 00		0.00	o	Ö		5. 00
6. 00		0.00	ő	o		6. 00
7. 00		0.00	0	0		1
			-1			7. 00
8. 00		0.00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10.00		0. 00	0	0		10. 00
11. 00		0.00	0	0		11. 00
12.00		0. 00	0	0		12. 00
13.00		0. 00	0	0		13. 00
14.00		0.00	0	0		14. 00
15.00		0.00	0	0		15. 00
16.00		0.00	o	0		16. 00
17.00		0.00	o	0		17. 00
18.00		0.00	o	0		18. 00
19. 00		0.00	o	Ö		19. 00
20. 00		0.00	o	Ö		20. 00
21. 00		0.00	Ö	o		21. 00
			-1			
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25.00		0. 00	0	0		25. 00
26.00		0.00	0	0		26. 00
27.00		0.00		0		27. 00
	TOTALS		0	11, 749, 443		
	B - MOB RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	28, 151		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	o	142, 337		2. 00
3.00	OPERATION OF PLANT	7. 00	o	71, 669		3. 00
4. 00	LAUNDRY & LINEN SERVICE	8. 00	ő	30, 644		4. 00
5. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	69, 351		5. 00
			0			1
6.00	RADI ATI ON-ONCOLOGY	54. 01	°	115, 571		6.00
7.00	LABORATORY	60.00	0	4, 599		7. 00
8. 00	PHYSI CAL THERAPY	66. 00	0	25, 110		8. 00
9. 00	OCCUPATI ONAL THERAPY	67. 00	0	25, 110		9. 00
10. 00	CLINIC	90.00		14 <u>2, 6</u> 16		10.00
	TOTALS		0	655, 158		
	C - CAFETERIA RECLASS					
1.00	CAFETERI A	11. 00	1, 306, 122	933, 014		1. 00
	TOTALS		1, 306, 122	933, 014		
	D - IMPLANTABLE DEVICE RECLAS	SS				
1.00	IMPL. DEV. CHARGED TO	72.00	0	11, 048, 726		1. 00
1.00	PATI ENT	72.00	Ĭ	11,010,720		1.00
2. 00	I ATTENT	0.00	o	0		2. 00
2.00	TOTALS — — — —			0 0 11, 048, 726		2.00
			U	11,046,720		
4 00	E - BONUS/PTO RECLASS	4 00	700 007			4 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	730, 307	0		1.00
2.00		0.00	0	0		2. 00
3.00		0. 00	0	0		3. 00
4.00		0. 00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	o	0		7. 00
8.00		0.00	o	0		8. 00
9.00		0.00	o	0		9. 00
10.00		0.00	o	Ö		10. 00
11. 00		0.00	o	0		11. 00
		0.00	o			•
12.00			-	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15. 00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17.00		0. 00	0	0		17. 00
18.00		0.00	0	0		18. 00
19.00		0. 00	O	0		19. 00
20.00		0.00	O	0		20. 00
21. 00		0.00	o	Ö		21. 00
22. 00		0.00	ő	o		22. 00
23. 00		0.00	o	0		23. 00
24. 00		0.00	o	0		24. 00
27.00	I .	0.00	<u> </u>	U	l	1 24.00

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: 7/30/2021 3:06 pm Provider CCN: 15-0005

					7/30/2021 3:0)6 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
25. 00	2. 00	3.00	4.00	5.00		25. 00
26. 00		0.00	0	0		26. 00
27. 00		0.00	ő	0		27. 00
28. 00		0.00	o	0		28. 00
29. 00		0.00	o	0		29. 00
30.00		0.00	o	0		30. 00
31.00		0. 00	0	0		31. 00
32. 00		0. 00	0	0		32. 00
33. 00		0.00	0	0		33.00
34. 00 35. 00		0. 00 0. 00	o O	0		34. 00 35. 00
36. 00		0.00	o	0		36. 00
37. 00		0.00	o	Ö		37. 00
38. 00		0.00	О	0		38. 00
39. 00		0.00	0	0		39. 00
40.00		0. 00	0	0		40. 00
41. 00		0.00	0	0		41.00
42. 00 43. 00		0. 00 0. 00	0	0		42.00
44. 00		0.00	0	0		43. 00 44. 00
45. 00		0.00	0			45. 00
	TOTALS — — — —		730, 307			
	F - MEDICAL SUPPLY RECLASS	'	· '	<u>"</u>		
1.00	OPERATING ROOM	50.00	0	2, 323, 453		1. 00
2.00	SPEECH PATHOLOGY	68. 00	0	451		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5. 00 6. 00		0. 00 0. 00	ol Ol	0		5. 00 6. 00
7. 00		0.00	o	0		7. 00
8. 00		0.00	o	0		8. 00
9.00		0.00	o	0		9. 00
10.00		0.00	o	0		10. 00
11. 00		0. 00	0	0		11. 00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	o	0		14. 00 15. 00
16. 00		0.00	o	0		16. 00
17. 00		0.00	o	0		17. 00
18.00		0.00	О	0		18. 00
19. 00		0.00	0	0		19. 00
20. 00		0. 00	0	0		20. 00
21. 00		0.00	0	0		21. 00
22. 00 23. 00		0. 00 0. 00	0	0		22. 00 23. 00
24. 00		0.00	o	0		24. 00
25. 00		0. 00	o	0		25. 00
26. 00		0.00	Ö	0		26. 00
27.00		0. 00	o	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30. 00 31. 00		0. 00 0. 00	0	0		30. 00 31. 00
31.00		0.00	0	0		31.00
33. 00		0.00	0	0		33. 00
34. 00		0.00	o	0		34. 00
35.00		0.00	0	0		35. 00
	TOTALS		0	2, 323, 904		
	G - HIM RECLASS	ı		1		
1. 00	MEDICAL RECORDS & LIBRARY	<u>16.</u> 00	2 <u>4, 0</u> 58	1 <u>8, 660</u>		1. 00
	TOTALS H - HEALTH INSURANCE RECLASS		24, 058	18, 660		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	ol	2, 816		1. 00
2.00	LWFLOTEL BENEFITS DEPARTMENT	0.00	o	2, 810		2. 00
2.00	TOTALS — — — —		— — — ў	2, 816		2.00
	I - CHILDBIRTH CENTER RECLASS	j		2,010		
1.00	NURSERY	43. 00	1, 428, 613	224, 176		1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	<u>2, 766, 0</u> 47	43 <u>4, 0</u> 45		2. 00
	TOTALS		4, 194, 660	658, 221		
1 00	J - MEDICAL DIRECTOR RECLASS	F 00	107 400	<u></u>		1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL	5. 00 0. 00	137, 433	0		1. 00 2. 00
2.00	TOTALS — — — —		0 137, 433	<u>0</u>		2.00
	1.020		107, 400	U		

Health Financial Systems

HENDRICKS REGIONAL HEALTH

In Lieu of Form CMS-2552-10

Provider CCN: 15-0005

Period:
From 01/01/2020
To 12/31/2020
Date/Time Prepared:
7/30/2021 3: 06 pm

						//30/2021 3:0	06 pm
	Increases						
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3.00	4.00	5. 00			
500.00	Grand Total: Increases		6, 392, 580	27, 389, 942	-		500.00

Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/30/2021 3:06 pm

		Decreases				7/30/2021 3:0)6 pm
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9. 00	10.00		
	A - DRUGS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	13, 000	l .		1. 00
2.00	HOUSEKEEPI NG	9.00	0	34			2. 00
3.00	NURSING ADMINISTRATION	13.00	0	937, 059	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	2, 585	0		4.00
5. 00 6. 00	PHARMACY SOCIAL SERVICE	15. 00 17. 00	0	10, 585, 983 1, 056	-		5. 00 6. 00
7. 00	ADULTS & PEDIATRICS	30.00	ol Ol	4, 229	0		7.00
8. 00	INTENSIVE CARE UNIT	31.00	Ö	1, 632	0		8. 00
9. 00	OPERATING ROOM	50.00	o	17, 840	o		9. 00
10.00	ENDOSCOPY	50. 01	0	2, 222	0		10.00
11.00	RECOVERY ROOM	51.00	O	521	0		11. 00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	411	0		12. 00
13. 00	ANESTHESI OLOGY	53. 00	0	42	0		13. 00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	0	53, 376	0		14.00
15.00	RADI ATI ON-ONCOLOGY NUCLEAR MEDI CI NE	54. 01	0	2, 300	0		15. 00 16. 00
16. 00 17. 00	CARDIAC CATHETERIZATION	56. 01 59. 00	ol Ol	61, 138 3, 932	0		17. 00
18. 00	LABORATORY	60.00	Ö	13	0		18. 00
19. 00	INTRAVENOUS THERAPY	64.00	Ö	495	0		19. 00
20. 00	RESPIRATORY THERAPY	65. 00	o	6, 371	o		20.00
21.00	PHYSI CAL THERAPY	66.00	0	27, 805	0		21. 00
22.00	OCCUPATI ONAL THERAPY	67. 00	0	20, 704	0		22. 00
23.00	ELECTROCARDI OLOGY	69.00	0	339	0		23. 00
24. 00	CARDI AC REHAB	69. 01	0	6	0		24. 00
25. 00	RENAL DI ALYSI S	74.00	0	162	0		25. 00
26. 00	CLINIC EMERCENCY	90.00	0	2, 837	0		26. 00
27. 00	EMERGENCY	91.00	0	<u>3, 3</u> 51 11, 749, 443	9		27. 00
	B - MOB RECLASS		UU	11, 747, 443			
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	655, 158	0		1.00
2.00		0.00	O	0	0		2. 00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4. 00
5.00		0.00	0	0	0		5. 00
6.00		0.00	0	0	0		6. 00
7.00		0.00	0	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0	0		8. 00 9. 00
10. 00		0.00	o	0	0		10.00
10.00	TOTALS — — — — —	 	— — 	655, 158			10.00
	C - CAFETERIA RECLASS		-,		,		
1.00	DI ETARY	10.00	1, 306, 122	933, 014	0		1. 00
	TOTALS		1, 306, 122	933, 014			
	D - IMPLANTABLE DEVICE RECLAS						
1.00	CLINIC	90.00	0	820, 669	1		1.00
2. 00	OPERATING ROOM	50.00		10, 228, 057	9		2. 00
	TOTALS E - BONUS/PTO RECLASS		<u> </u>	11, 048, 726			
1.00	ADMI NI STRATI VE & GENERAL	5.00	64, 889	0	0		1.00
2. 00	OPERATION OF PLANT	7.00	13, 181	0	1		2. 00
3.00	LAUNDRY & LINEN SERVICE	8.00	1, 773	0	0		3. 00
4.00	HOUSEKEEPI NG	9.00	12, 967	0	0		4. 00
5.00	DI ETARY	10.00	3, 368	0	0		5. 00
6.00	CAFETERI A	11. 00	6, 111	0	0		6. 00
7.00	NURSING ADMINISTRATION	13.00	28, 438	0	0		7. 00
8.00	CENTRAL SERVICES & SUPPLY	14.00	5, 304	0	0 0		8. 00
9. 00 10. 00	PHARMACY MEDICAL RECORDS & LIBRARY	15. 00 16. 00	12, 262 3, 066	0	0		9. 00 10. 00
11. 00	SOCIAL SERVICE	17. 00	9, 198	0	0		11. 00
12. 00	ADULTS & PEDIATRICS	30.00	66, 524	0	0		12. 00
13.00	INTENSIVE CARE UNIT	31.00	14, 882	0	0		13.00
14.00	NURSERY	43.00	6, 684	0	0		14. 00
15. 00	OPERATING ROOM	50.00	12, 393	0	0		15. 00
16. 00	ENDOSCOPY	50. 01	4, 744	0	0		16. 00
17. 00	RECOVERY ROOM	51.00	6, 615	0	0		17. 00
18.00	DELIVERY ROOM & LABOR ROOM	52.00	12, 941	0	0		18.00
19. 00	ANESTHESI OLOGY	53.00	31, 931	0	0		19.00
20. 00 21. 00	RADI OLOGY-DI AGNOSTI C RADI ATI ON-ONCOLOGY	54. 00 54. 01	29, 369 6, 403	0	0		20. 00 21. 00
21.00	NUCLEAR MEDICINE	56. 01	966	0	0		21.00
23. 00	CARDIAC CATHETERIZATION	59.00	2, 707	n	0		23. 00
24. 00	LABORATORY	60.00	15, 938	0			24. 00
25. 00	I NTRAVENOUS THERAPY	64.00	4, 724	0	l I		25. 00
	•		· · ·	-			

Peri od: From 01/01/2020 To 12/31/2020

Date/Time Prepared: 7/30/2021 3:06 pm

COST. CORTOR COST. CORTOR COST. CORTOR COST. COST. COST. COST. COST. COST. COST. COST. COST. COST. COST. COST. COST. COST. COST.							7/30/2021 3:	06 pm
December 1,000			Decreases	0.1	0.1		I	
2.00 PRIFEIRATION THERAPY 6.6.00 2.100 0 0 2.7.00								
27. 00 PAYS LOAD TUPERAPY 66. 00 25, 510 0 0 27. 00 28, 510 0 0 0 27. 00 28, 510 0 0 0 28, 510 0 0 0 28, 510 0 0 0 28, 510 0 0 0 28, 510 0 0 0 28, 510 0 0 0 28, 510 0 0 0 28, 510 0 0 0 28, 510 0 0 0 0 0 0 0 0 0								
29.00 OCCUPATIONAL TIRRAPY O. 7.00 2.700 O. 2.7		1						1
29-00		1						1
30.00 ELECTROCARDIO GOY 09.00 4,182 0 0 33.00 33								1
31 00		1					l .	1
1.00	30.00	ELECTROCARDI OLOGY	69. 00	4, 183	0			30. 00
1.00 STAR SOUND 73 01 2,807 0 0 33,00	31.00	CARDI AC REHAB	69. 01	2, 612	0			31. 00
34.00 CRAN_DIALYSIS	32.00	ELECTROENCEPHALOGRAPHY	70.00	580	0	0		32. 00
S. O. CLINIC 90 00 7, 325	33.00	ULTRA SOUND	73. 01	2, 867	0	0		33. 00
BERECENCY	34.00	RENAL DIALYSIS	74.00	1	0	0		34. 00
37.00 PAYSICLANS PRIVATE OFFICES 192.00 229,260 0 0 33.00 98.00 PATH ITADASS 192.01 14,885 0 0 0 38.00 98.00 99.00 0 39.00	35.00	CLINIC	90.00	7, 325	0	0		35. 00
REALTH TRACKS 192 01 14,885 0 0 38,000	36.00	EMERGENCY	91.00	31, 046	0	0		36. 00
39.00 DIMMARY CARE CLINIC 194.00 4.315 0 0 40.00 0.00	37.00	PHYSICIANS' PRIVATE OFFICES	192.00	223, 260	0	0		37. 00
40.00 OCCUPATIONAL MEDICINE 194.09 1,989 0 0 0 40.00 41.00 FORMATION 194.08 700 0 0 0 141.00 42.00 SCHOOL & TOWN CLINICS 194.09 0,744 0 0 0 0 42.00 43.00 MAMRGHED FACELITY 194.08 2,107 0 0 0 0 43.00 45.00 SIFF MORE CERTIFIED 194.07 6,236 0 0 0 0 45.00 1071.50 SIFF MORE CERTIFIED 194.07 6,236 0 0 0 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0	38.00	HEALTH TRACKS	192. 01	14, 885	0	0		38. 00
41.00 FORMINATION 194.03 704 0 0 41.00 42.00 43.00	39.00	PRIMARY CARE CLINIC	194.00	4, 315	0	0		39. 00
1.00 FOUNDATION 194, 03 704 0 0 41, 00 42, 00 43, 00 43, 00 43, 00 43, 00 43, 00 43, 00 43, 00 43, 00 44, 00 707, 40 70 70 70 70 70 70 70	40.00	OCCUPATIONAL MEDICINE	194. 02	1, 989	0	0		40. 00
42,00 SCHOOL & TOWN CLINICS	41.00		1		0	0		1
43.00 MANAGED FACILITY	42.00	SCHOOL & TOWN CLINICS	194. 04	6. 744	0	0		42.00
44, 00			1		0		1	1
45.00 SNF NON CERTIFIED		1	1	1	0	0		1
TOTALS F - MEDICAL SUPPLY RECLASS 1.00				6, 236			l .	1
F - MEDICAL SUPPLY RECLASS								1
1.00			1					1
2.00 AMINI STRATI VE & CENERAL	1 00		4 00	0	829	0		1 00
3.00 CAMBRY & LINEN SERVICE		1		- 1				1
MOUSEKEEPING				- 1				1
5.00 DIETARY				-				1
6.00 MURSING ADMINISTRATION 13.00 0 9.2c1 0 6.00 7.00 8.00 PHARMACY 15.00 0 16.629 0 7.00 8.00 PHARMACY 15.00 0 21.880 0 8.00 9.00 SOCIAL SERVICE 17.00 0 185 0 9.00 10.00 ADULTS & PEDIATRICS 30.00 0 75.495 0 11.00 11.00 INTENSIVE CARE UNIT 31.00 0 75.495 0 11.00 12.00 ENDOSCOPY 50.01 0 66.875 0 12.00 14.00 ANESTHESIOLOGY 53.00 0 32.367 0 14.00 14.00 ANESTHESIOLOGY 53.00 0 32.367 0 14.00 16.00 RADIATION-ONCOLOGY 54.01 0 32.60 0 16.00 16.00 RADIATION-ONCOLOGY 54.01 0 32.60 0 16.00 18.00 CARDIAK CANTETERIZTON 59.00 0 270.458 0 18.00 18.00 CARDIAK CANTETERIZTON 59.00 0 270.458 0 18.00 19.00 LABORITON THERRAY 65.00 0 46.221 0 22.00 PHYSICAL THERRAY 66.00 0 46.221 0 23.00 CAUCUPATIONAL THERRAY 67.00 0 46.221 0 24.00 EESPIRATION THERRAY 67.00 0 48.822 0 22.00 25.00 CARDIAK CEATHERISTON 73.01 0 2.300 0 2.200 26.00 CARDIAK CEATHERISTON 73.01 0 2.300 0 2.200 27.00 RESPIRATION THERRAY 67.00 0 46.221 0 0 28.00 CARDIAK CEATHERISTON 73.01 0 2.300 0 2.000 29.00 PHYSICAL THERRAY 67.00 0 46.921 0 0 20.00 CARDIAK CEATHERISTON 73.01 0 2.300 0 0 20.00 CARDIAK CEATHERISTON 73.01 0 2.300 0 20.00 CARDIAK CEATHERISTON 74.000 0 3.890 0 2.200 20.00 CARDIAK CEATHERISTON 74.000 0 3.890 0				- 1	6		1	1
7. 00 CENTRAL SERVICES & SUPPLY 14, 00 0 16, 629 0 7, 00 8, 00 9, 00 9, 00 9, 00 10, 10 11, 10 10, 10 11, 10 10, 10 11, 10		1		-	0 261		l .	1
B. 00 PHARMACY				-			l .	1
9.00 SOCIAL SERVICE 17.00 0 185 0 9.00 10.00 ADULTS & PEDIATRICS 30.00 0 98, 277 0 11.00 11.00 INTENSIVE CARE UNIT 31.00 0 75, 495 0 11.00 12.00 ENDOSCOPY 50.01 0 66, 875 0 12.00 13.00 RECOVERY ROOM 51.00 0 2, 995 0 13.00 15.00 RECOVERY ROOM 51.00 0 2, 995 0 14.00 15.00 RADIOLOGY DIAGNOSTIC 54.00 0 188, 214 0 15.00 16.00 RADIOLOGY DIAGNOSTIC 54.00 0 188, 214 0 15.00 17.00 RADIOLOGY DIAGNOSTIC 54.01 0 326 0 16.00 17.00 NUCLEAR MEDICINE 56.01 0 534 0 17.00 17.00 NUCLEAR MEDICINE 56.01 0 2.685 0 18.00 17.00 NUCLEAR MEDICINE 56.01 0 2.685 0 17.00 17.00 NUCLEAR MEDICINE 56.01 0 0 2.685 0 17.00 17.00 NUCLEAR MEDICINE 56.01 0 0 2.685 0 0 2.00 17.00 NUCLEAR MEDICINE 56.01 0 0 2.685 0 0 2.00 17.00 NUCLEAR MEDICINE 56.01 0 0 0 0 0 0 17.00 NUCLEAR MEDICINE 57.00 0 0 0 0 0 0 17.00 NUCLEAR MEDICINE 57.00 0 0 0 0 0 0 17.00 NUCLEAR MEDICINE 57.00 0 0 0 0 0 0 0 17.00 NUCLEAR MEDICINE 50.00 0 0 0 0 0 0 0 0 0		1		0			l .	1
10.00 ADULTS & PEDIATRICS 30.00 0 98.277 0 11.00		1		0				1
11.00 INTENSIVE CARE UNIT 31.00 0 75,495 0 11.00 12.00 ENDOSCOPY 50.01 0 0 66,875 0 12.00 13.00 RECOVERY ROOM 51.00 0 2,995 0 13.00 14.00 RECOVERY ROOM 51.00 0 2,995 0 14.00 15.00 RADI OLOGY - DI AGNOSTIC 54.00 0 188.214 0 15.00 16.00 RADI OLOGY - DI AGNOSTIC 54.01 0 32.6 0 16.00 17.00 RADI OLOGY - DI AGNOSTIC 54.01 0 32.6 0 16.00 17.00 NUCLEAR MEDI CINE 56.01 0 53.4 0 17.00 17.00 NUCLEAR MEDI CINE 56.01 0 53.4 0 17.00 18.00 CARDI AC CATHETERI ZATI ON 59.00 0 2.70,458 0 18.00 19.00 LABORATORY 66.00 0 2.685 0 19.00 19.00 LABORATORY 64.00 0 5.600 0 20.00 19.00 LABORATORY THERAPY 66.00 0 46.231 0 21.00 10.00 CENTRAL THERAPY 66.00 0 48.322 0 22.00 22.00 PSTAN STAN STAN STAN STAN STAN STAN STAN		l I		0				1
12.00 ENDOSCOPY 50.01 0 66,875 0 12.00		1		0				1
13.00 RECOVERY ROOM 51.00 0 2,995 0 13.00 14.00 15.00 14.00 15.00 14.00 15.00 16.00 18.214 0 15.00 16.00 18.214 0 15.00 16.00 16.00 17.00 RADI ATI ON-DINCOLOGY 54.01 0 32.367 0 16.00 17.00 1		l I		U				1
14. 00 AMESTHESI OLOGY		1		0	·			1
15. 00 RADI 0LOGY-DI AGNOSTI C 54. 00 0 18. 214 0 15. 00 16. 00 17. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18		1						1
16.00 RADI ATI ON-ONCOLOGY 54.01 0 326 0 16.00		1		-			l .	1
17. 00 NUCLEAR MEDICINE 56. 01 0 534 0 17. 00				-				1
18. 00		1		-			1	1
19. 00 LABORATORY 60. 00 0 2, 685 0 19. 00 1NTRAVENOUS THERAPY 65. 00 0 5, 600 0 21. 00 RESPIRATORY THERAPY 65. 00 0 46, 231 0 21. 00 22. 00 PHYSI CAL THERAPY 66. 00 0 37, 183 0 22. 00 23. 00 COLUPATI ONAL THERAPY 66. 00 0 37, 183 0 22. 00 24. 00 ELECTROCARDI OLOGY 69. 00 0 1, 654 0 24. 00 25. 00 CABDI ACE HEB 69. 01 0 899 0 25. 00 26. 00 ULTRA SOUND 73. 01 0 2, 320 0 26. 00 27. 00 RENAL DI ALYSI S 74. 00 0 58 0 27. 00 28. 00 EMERGENCY 91. 00 0 48, 997 0 28. 00 29. 00 PHYSI CLANS' PRIVATE OFFICES 192. 00 0 1, 4740 0 30. 00 31. 00 PRIMARY CARE CLINIC 194. 00 0 2, 456 0 31. 00 32. 00 OCUPATI ONAL MEDICINE 194. 00 0 343 0 33. 00 33. 00 SCHOOL & TOWN CLINICS 194. 04 0 343 0 33. 00 34. 00 MANAGED FACILLITY 194. 05 0 2, 323, 304 0 35. 00 SMIN INSTRATIVE & SENERAL 5. 00 24, 058 18, 660 10 1. 00 TOTALS		1		-				1
20. 00 NTRAVENOUS THERAPY			1	0				1
21.00 RESPIRATORY THERAPY 65.00 0 46,231 0 22.00		1		0			l .	1
22. 00		1	1	-			1	1
23. 00 CCUPATI ONAL THERAPY 67. 00 0 4,832 0 23. 00 24. 00 24. 00 24. 00 24. 00 24. 00 24. 00 25. 00 26. 00 0 0 1,654 0 0 27. 00 26. 00 0 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 29. 00 29. 00 29. 00 0 1,359,367 0 29. 00 31. 00 29. 00 31. 00 24. 456 0 31. 00 29. 00 31. 00 24. 456 0 32. 00 27. 00 28. 00 29. 00 28. 00 29. 00 28. 00 29. 00 28. 00 29. 00 28. 00 29. 00 28. 00 29. 00 28. 00 29. 00 28. 00 29. 00 28. 00 29. 00 28. 00 29. 00 28. 00 29. 00 28. 00 29.		1		0	46, 231		l .	1
24. 00 ELECTROCARDI OLOGY 69. 00 0 1,654 0 24. 00 25. 00 CARDI AC REHAB 69. 01 0 899 0 25. 00 27. 00 READL DI LAYSIS 74. 00 0 58 0 27. 00 28. 00 EMERGENCY 91. 00 0 48. 997 0 28. 00 29. 00 PHYSI CI ANS' PRI VATE OFFICES 192. 00 0 1,359, 367 0 29. 00 30. 00 HEALTH TRACKS 192. 01 0 14. 740 0 30. 00 31. 00 PRI MARY CARE CLI NI C 194. 00 0 2,456 0 31. 00 31. 00 PRI MARY CARE CLI NI C 194. 00 0 343 0 32. 00 33. 00 SCHOOL & TOWN CLI NI CS 194. 04 0 343 0 33. 00 34. 00 MANAGED FACI LI TY 194. 05 0 2 0 0 35. 00 SNE NON CERTIFLED 194. 07 0 1,577 0 35. 00 SNE NON CERTIFLED 194. 07 0 1,577 0 35. 00 ADMINISTRATI VE & GENERAL 5. 00 24. 058 18. 660 0 36. 00 COURTAL SERVI CES & SUPPLY 14. 00 0 2,395 0 37. 00 COURTAL SERVI CES & SUPPLY 14. 00 0 2,395 0 38. 00 COURTAL SERVI CES & SUPPLY 14. 00 0 2,395 0 39. 00 COURTAL SERVI CES & SUPPLY 14. 00 0 2,395 0 39. 00 COURTAL SERVI CES & SUPPLY 14. 00 0 2,395 0 39. 00 COURTAL SERVI CES & SUPPLY 14. 00 0 2,395 0 39. 00 COURTAL SERVI CES & SUPPLY 14. 00 0 2,395 0 39. 00 COURTAL SERVI CES & SUPPLY 14. 00 0 0 2,395 0 39. 00 COURTAL SERVI CES & SUPPLY 14. 00 0 0 0 0 39. 00 COURT CLIDBIRTH CENTER RECLASS 0 0 0 0 39. 00 O 0 0 0 0 0 39. 00 O 0 0 0 0 39. 00 O				0	37, 183		l .	1
25. 00 CARDI AC REHAB 69. 01 0 899 0 25. 00 26. 00 ULTRA SOUND 73. 01 0 2, 320 0 26. 00 27. 00 RENAL DIALYSIS 74. 00 0 588 0 27. 00 28. 00 EMERGENCY 91. 00 0 48, 997 0 28. 00 29. 00 PHYSICI ANS' PRIVATE OFFICES 192. 00 0 1, 359, 367 0 29. 00 29. 00 PHYSICI ANS' PRIVATE OFFICES 192. 01 0 14, 740 0 30. 00 31. 00 PRI MARY CARE CLINIC 194. 00 0 2, 456 0 31. 00 32. 00 OCCUPATI ONAL MEDICI NE 194. 02 0 367 0 32. 00 33. 00 SCHOOL & TOWN CLINICS 194. 04 0 343 0 33. 00 34. 00 MANAGED FACI LITY 194. 05 0 2 0 343 35. 00 SM P NON CERTIFIED 194. 07 0 1,577 0 35. 00 TOTALS 0 0 2, 323, 904 0 1. 00 ADMINISTRATIVE & GENERAL 5. 00 24, 058 18, 660 0 1. 00 2. 00 CENTRAL SERVICES & SUPPLY 14. 00 2,816 1 1 CHILDBIRTH CENTER RECLASS 1. 00 ADMINISTRATIVE RECLASS 1. 00 ADMINISTRA	23.00		67.00	0	4, 832	0		23. 00
26. 00 ULTRA SOUND 73. 01 0 2, 320 0 27. 00 RENAL DI ALYSI S 74. 00 0 58 0 27. 00 27. 00 RENAL DI ALYSI S 74. 00 0 58 0 27. 00 29. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 1, 359, 367 0 29. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 1, 359, 367 0 29. 00 30. 00 HEALTH TRACKS 192. 01 0 14, 740 0 30. 00 22. 00 31. 00 PRI MARY CARE CLINI C 194. 00 0 2, 456 0 31. 00 32. 00 0 CCUPATI ONAL MEDI CI NE 194. 02 0 367 0 32. 00 33. 00 0 CCUPATI ONAL MEDI CI NE 194. 02 0 367 0 32. 00 33. 00 0 CMANAGED FACI LITY 194. 05 0 2 0 343 0 33. 00 34. 00 MANAGED FACI LITY 194. 05 0 2 0 34. 00 34. 00 MANAGED FACI LITY 194. 05 0 2 0 34. 00 35. 00 SWR NON CERTI FIED 194. 07 0 1,577 0 35. 00 35. 00 5WR NON CERTI FIED 194. 07 0 1,577 0 35. 00 5WR NON CERTI FIED 194. 07 0 2,323,904 0 35. 00 0 2,323,904 0 0 0 0 2,323,904 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24.00	ELECTROCARDI OLOGY	69. 00	0	1, 654		l .	24. 00
27.00 RENAL DI ALYSIS 74.00 0 58 0 27.00 28.00 EMERGENCY 91.00 0 48,997 0 28.00 29.00 94.997 0 29.00 30.00 HEALTH TRACKS 192.00 0 1,359,367 0 30.00 31.00 PRI MARY CARE CLINIC 194.00 0 2,456 0 31.00 32.00 32.00 0.00 0.00 0.00 0 0 0 0	25. 00	CARDI AC REHAB	69. 01	0	899	0		25. 00
28. 00 EMERGENCY 91. 00 0 48, 997 0 29. 00 29. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 1, 359, 367 0 29. 00 30. 00 HEALTH TRACKS 192. 01 0 14, 740 0 0 30. 00 31. 00 PRI MARY CARE CLINIC 194. 00 0 2, 456 0 31. 00 32. 00 OCCUPATIONAL MEDICINE 194. 02 0 367 0 32. 00 33. 00 SCHOOL & TOWN CLINICS 194. 04 0 343 0 33. 00 34. 00 MANAGED FACILITY 194. 05 0 2 0 0 35. 00 SN NON CERTIFIED 194. 07 0 1,577 0 35. 00 G - HIM RECLASS	26.00	ULTRA SOUND	73. 01	0	2, 320	0		26. 00
29.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 1,359,367 0 29.00	27.00	RENAL DIALYSIS	74.00	0	58	0		27. 00
30. 00 HEALTH TRACKS	28.00	EMERGENCY	91.00	0	48, 997	0		28. 00
31. 00 PRIMARY CARE CLINIC 194. 00 0 2. 456 0 32. 00 32. 00 OCCUPATI ONAL MEDICINE 194. 02 0 367 0 32. 00 33. 00 SCHOOL & TOWN CLINICS 194. 04 0 343 0 33. 00 34. 00 MANAGED FACILITY 194. 05 0 2 0 34. 00 35. 00 SNF NON CERTIFIED 194. 07 0 1.577 0 35. 00 TOTALS 0 2. 323. 904 6 18. 660 1 1. 00 ADMINISTRATIVE & GENERAL 5. 00 24. 058 18. 660 0 1. 00 TOTALS 1. 00 RESPIRATORY THERAPY 65. 00 0 421 0 2. 00 TOTALS 0 0 2. 395 0 1. 00 RESPIRATORY THERAPY 65. 00 0 421 0 2. 00 TOTALS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1, 359, 367	0		29. 00
32. 00 OCCUPATI ONAL MEDI CI NE 194. 02 0 367 0 32. 00 33. 00 SCHOOL & TOWN CLINICS 194. 04 0 343 0 333. 00 34. 00 MANAGED FACILITY 194. 05 0 2 0 34. 00 35. 00 SNF NON CERTI FIED 194. 07 0 1,577 0 35. 00 SNF NON CERTI FIED 2,40.07 0 1,577 0 35. 00 G - HIM RECLASS 2 0 2,323,904 2 1. 00 ADMINISTRATI VE & GENERAL 5. 00 24,058 18,660 0 1. 00 TOTALS 0 24,058 18,660 0 1. 00 H - HEALTH INSURANCE RECLASS 18.00 0 2,395 0 1. 00 2. 00 RESPIRATORY THERAPY 65. 00 0 421 0 2. 00 TOTALS 0 0 2,3816 1 0 0 2. 3616 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00	HEALTH TRACKS	192. 01	0	14, 740	0		30.00
33. 00 SCHOOL & TOWN CLINICS 194. 04 0 343 0 33. 00 34. 00 34. 00 34. 00 34. 00 34. 00 34. 00 34. 00 35. 00 SNF NON CERTIFIED 194. 07 0 1,577 0 35. 00 0 0 0 0 0 0 0 0 0	31.00	PRIMARY CARE CLINIC	194. 00	0	2, 456	0		31. 00
34. 00 MANAGED FACILITY 194. 05 0 2 0 34. 00 35. 00 SNF NON CERTIFIED 194. 07 0 1,577 0 35. 00 SNF NON CERTIFIED 194. 07 0 2,323,904	32.00	OCCUPATIONAL MEDICINE	194. 02	0	367	0		32. 00
35.00 SNF NON CERTIFIED 194.07 0 1,577 0 1 35.00 TOTALS 0 2,323,904	33.00	SCHOOL & TOWN CLINICS	194. 04	O	343	0		33. 00
TOTALS	34.00	MANAGED FACILITY	194. 05	0	2	0		34. 00
1. 00 ADMI NI STRATI VE & GENERAL	35.00	SNF NON CERTIFIED	194. 07	O	1, 577	0		35. 00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 24, 058 18, 660 0 1 1. 00 TOTALS 24, 058 18, 660 1 1. 00		TOTALS			2, 323, 904			İ
TOTALS		G - HIM RECLASS	•					1
TOTALS	1.00	ADMINISTRATIVE & GENERAL	5.00	24, 058	18, 660	0		1.00
1. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 2, 395 0 2. 00								
1. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 2, 395 0 2. 00		H - HEALTH INSURANCE RECLASS	•		·			1
2.00 RESPIRATORY THERAPY 65.00 0 421 0 2.00 TOTALS 0 2.00 2,816 1 - CHI LDBI RTH CENTER RECLASS 1.00 ADULTS & PEDI ATRI CS 30.00 4, 194, 660 658, 221 0 2.00 TOTALS	1.00		14.00	0	2, 395	0		1 1.00
TOTALS 1 - CHI LDBI RTH CENTER RECLASS		RESPIRATORY THERAPY		0			1	1
1 - CHI LDBI RTH CENTER RECLASS 30.00 4,194,660 658,221 0 0 0 0 0 0 0 0 0			— 	— — <u> </u>		<u> </u>	1	
1. 00 ADULTS & PEDIATRICS 30. 00 4, 194, 660 658, 221 0 0 2. 00 2. 00 2. 00 0 0 2. 00 0 0 0 0				ال	2,010			1
2. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00			4 194 660	658 221	0		1 00
TOTALS		LIBETO & LEDITINIOS		1, 174, 000	000, 221 N		1	1
J - MEDICAL DIRECTOR RECLASS 1.00 PHYSICIANS' PRIVATE OFFICES 192.00 131,133 0 0 1.00 2.00 SCHOOL & TOWN CLINICS 194.04 6,300 0 0 2.00 TOTALS 137,433 0	2.00	TOTALS — — — —	— — 	4 194 660		<u> </u>	1	2.00
1. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 131, 133 0 0 0 2. 00 SCHOOL & TOWN CLI NI CS 194. 04 6, 300 0 0 0 TOTALS 137, 433 0				7, 174, 000	030, 221		I	1
2. 00 SCHOOL & TOWN CLINICS 194. 046, 300 0 0 0 2. 00 2. 00	1 00		102 00	121 122	0	0		1 00
TOTALS 137, 433 0		1			0		l .	1
	∠. ∪∪		— — 1 74. U4			— — ^u	†	2.00
0, 372, 300 21, 307, 742 500. 00	500 00				27 200 042		†	500.00
	300.00	or and Total. Decreases		0, 372, 300	21, 307, 742	<u> </u>	I	1 300. 00

	om
Beginning Balances Purchases Donation Total Disposals and Retirements 1.00 2.00 3.00 4.00 5.00	
Ball ances Retirements 1.00 2.00 3.00 4.00 5.00	
1.00 2.00 3.00 4.00 5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	
	1. 00
	2.00
	3.00
	4.00
	5.00
6.00 Movable Equipment 0 0 0 0	6. 00
7.00 HIT designated Assets 0 0 0 0	7.00
8.00 Subtotal (sum of lines 1-7) 475,074,508 8,064,268 0 8,064,268 11,851,205	8. 00
9.00 Reconciling I tems 0 0 0 0	9. 00
10. 00 Total (line 8 minus line 9) 475, 074, 508 8, 064, 268 0 8, 064, 268 11, 851, 205 1	0.00
Ending Balance Fully	
Depreciated	
Assets	
6.00 7.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	
1. 00 Land 18, 926, 206 0	1.00
2.00 Land Improvements 9,993,537 0	2.00
3.00 Buildings and Fixtures 297,514,437 0	3.00
4.00 Building Improvements 0 0	4.00
5.00 Fi xed Equipment 144,853,391 0	5.00
6.00 Movable Equipment 0 0	6. 00
7.00 HIT designated Assets 0 0	7. 00
8.00 Subtotal (sum of lines 1-7) 471, 287, 571 0	8. 00
	9. 00
	0. 00

Heal th	Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lieu of Form CMS-2552-10			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0005	Peri od: From 01/01/2020 To 12/31/2020		pared:	
			SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10.00	11. 00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2				
1.00	NEW CAP REL COSTS-BLDG & FLXT	26, 230, 496	0		0	0	1. 00	
3.00	Total (sum of lines 1-2)	26, 230, 496	0		0 0	0	3. 00	
SUMMARY OF CAPITAL								
	Cost Center Description	Other	Total (1) (sum					
		Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	26, 230, 496			·	1. 00	
3.00	Total (sum of lines 1-2)	0	26, 230, 496				3. 00	

Health Financial Systems	HENDRI CKS RE	GIONAL HEALTH		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7		
			1 -	From 01/01/2020 o 12/31/2020		pared:	
					7/30/2021 3:06		
	CC	MPUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL		
Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance		
cost center bescription	GIOSS ASSETS	Leases	for Ratio	instructions)	Trisul dilec		
		200000	(col. 1 - col.	,			
			2)				
	1.00	2. 00	3.00	4. 00	5. 00		
PART III - RECONCILIATION OF CAPITA	L COSTS CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FLXT	471, 287, 57	•	471, 287, 571			1. 00	
3.00 Total (sum of lines 1-2)	471, 287, 57		471, 287, 571			3. 00	
	ALLOC	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
		Capi tal -Rel ate					
		d Costs	through 7)				
	6.00	7. 00	8. 00	9. 00	10.00		
PART III - RECONCILIATION OF CAPITA	L COSTS CENTERS		1	0 000 074			
1.00 NEW CAP REL COSTS-BLDG & FIXT				26, 303, 871	l .	1.00	
3.00 Total (sum of lines 1-2)			IMMADY OF CADIA	26, 303, 871	0	3. 00	
		50	JMMARY OF CAPIT	IAL			
Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum		
		instructions)	instructions)	Capi tal -Rel ate			
				d Costs (see	through 14)		
				instructions)			
DADT III DECONOLITATION OF CARLET	11.00	12. 00	13. 00	14. 00	15. 00		
PART III - RECONCILIATION OF CAPITA		ء ا			05 (75 007	4 00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	-628, 56		1	_		1.00	
3.00 Total (sum of lines 1-2)	-628, 56	64 0) C	0	25, 675, 307	3. 00	

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0005

				T	o 12/31/2020		
				Expense Classification on To/From Which the Amount is		7/30/2021 3:00	o piii
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1. 00 B	2. 00 -628, 564	3.00 NEW CAP REL COSTS-BLDG &	4. 00 1. 00	5. 00 11	1. 00
	REL COSTS-BLDG & FIXT (chapter 2)			FIXT			
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
8.00	21) Tellevision and radio service (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -14, 249, 594		0. 00	0 0	
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee and others		-893, 348 0	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
20. 00 21. 00	books, etc.) Vending machines Income from imposition of interest, finance or penalty		0		0. 00 0. 00	0	
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL			FIXT *** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00

				To	12/31/2020	Date/Time Prep 7/30/2021 3:00	
				Expense Classification on	Worksheet A	7/30/2021 3.00	э рііі
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
33. 00	1993 CARRYFORWARD	A	70, 087	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 00
33. 01	1994 CARRYFORWARD	A	3, 288	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 01
22.02	LATERECT EVENCE LONG TERM		0	FLXT	1 00	11	22.02
33. 02	INTEREST EXPENSE-LONG TERM CARE	A	U	NEW CAP REL COSTS-BLDG &	1. 00	11	33. 02
33. 03	ADMITTING TELEPHONE	A	-12, 114	ADMINISTRATIVE & GENERAL	5. 00	o	33. 03
33. 04	(EQUIPMENT) ADMITTING TELEPHONE (SALARY)	A	-23, 398	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	MARKETING DEPARTMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33. 06	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07 33. 08	I HA LOBBYING EXPENSE AHA LOBBYING EXPENSE	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 07 33. 08
33. 09	HOSPITAL ASSESSMENT FEE	A		ADMINISTRATIVE & GENERAL	5. 00	ő	33. 09
33. 10	HIP ASSESSMENT FEE	Α		ADMINISTRATIVE & GENERAL	5. 00	o	33. 10
33. 11	MEALS ON WHEELS	Α	-480, 318	1	10.00	0	33. 11
33. 12	REVENUE OTHER OPERATING	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 12
33. 13 33. 14	HRH BENEFITS EXPENSE HRH WELLNESS	B B	·	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	33. 13 33. 14
33. 15	JURY DUTY	B		EMPLOYEE BENEFITS DEPARTMENT	4.00	Ö	33. 15
33. 16	REVENUE OTHER OPERATING	В		ADMINISTRATIVE & GENERAL	5.00	0	33. 16
33. 17	CHAPLAI NCY	В		ADMINISTRATIVE & GENERAL	5.00	0	33. 17
33. 18 33. 19	FINANCIAL SERVICES GIFT SHOP	B B	·	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 18 33. 19
33. 19	NON-OPERATING HOSPITAL	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 19
	OVERHEAD		_				
33. 21	ANSWERING SERVICE	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 21
33. 22	REVENUE - OTHER OPERATING	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 22
33. 23 33. 24	OPERATIONAL EXCELLENCE REVENUE CYCLE	B B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 23 33. 24
33. 25	VOLUNTEER SERVICES	В		ADMINISTRATIVE & GENERAL	5. 00	Ö	33. 25
33. 26	GAIN FROM INSURANCE PROCEEDS	В		ADMINISTRATIVE & GENERAL	5.00	0	33. 26
33. 27	REVENUE OTHER OPERATING	В		OPERATION OF PLANT	7. 00	0	33. 27
33. 28 33. 29	REVENUE - OTHER OPERATING SUPPORT SERVICE	B B		OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	0 0	33. 28 33. 29
33. 30	EDUCATIONAL SERVICES	В		NURSING ADMINISTRATION	13. 00	0	33. 30
33. 31	REVENUE - OTHER OPERATING	В		NURSING ADMINISTRATION	13. 00	o	33. 31
33. 32	MATERIALS MANAGEMENT	В		CENTRAL SERVICES & SUPPLY	14. 00	0	33. 32
33. 33	PHARMACY	B B		PHARMACY	15.00	0	33. 33
33. 34 33. 35	REVENUE OTHER OPERATING REVENUE OTHER OPERATING	В		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	16. 00 17. 00	0	33. 34 33. 35
33. 36	TRANSITION OF CARE	В		SOCI AL SERVI CE	17. 00	Ö	33. 36
33. 37	CHILD BIRTH CENTER	В		ADULTS & PEDIATRICS	30.00	0	33. 37
33. 38	REVENUE OTHER OPERATING	В		ADULTS & PEDIATRICS	30.00	0	
33. 39 33. 40	OPERATING ROOM REVENUE - OTHER OPERATING	B B		OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0	33. 39 33. 40
33. 41	ONCOLOGY INFUSION CENTER	В		RADI ATI ON-ONCOLOGY	54. 01		33. 41
33. 42	REVENUE - OTHER OPERATING	В	·	RADI ATI ON-ONCOLOGY	54. 01	0	33. 42
33. 43	CARDIAC CATH LAB	В		CARDIAC CATHETERIZATION	59. 00	0	33. 43
33. 44	LABORATORY THERADY	В		LABORATORY	60.00	0	33. 44
33. 45 33. 46	RESPIRATORY THERAPY HRH SPORTS MEDICINE PHYSICIAN	B B		RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00 66. 00	0	33. 45 33. 46
33. 47	PHYSI CAL THERAPY	В		PHYSI CAL THERAPY	66.00	Ö	33. 47
33. 48	PHYSICAL THERAPY - AVON	В		PHYSI CAL THERAPY	66.00	o	33. 48
33. 49	PHYSICAL THERAPY - BROWNSBURG	В		PHYSI CAL THERAPY	66.00	0	33. 49
33. 50 33. 51	PHYSICAL THERAPY - PLAINFIELD SPORTS MEDICINE	B B	·	PHYSI CAL THERAPY PHYSI CAL THERAPY	66. 00 66. 00	0 0	33. 50 33. 51
33. 51	REVENUE - OTHER OPERATING	В		PHYSICAL THERAPY	66.00	0	33. 51
33. 53	OCCUPATI ONAL THERAPY REHAB	В		OCCUPATI ONAL THERAPY	67. 00	0	33. 53
33. 54	CARDI AC REHABI LI TATI ON	В		CARDI AC REHAB	69. 01	0	33. 54
33. 55	REVENUE - OTHER OPERATING	B B		ULTRA SOUND	73. 01	0	33. 55
33. 56 33. 57	HI BBELN SURGERY CENTER EMERGENCY DEPARTMENT	B B		CLINIC EMERGENCY	90. 00 91. 00	0	33. 56 33. 57
33. 58	EMS PROGRAM	В		EMERGENCY	91.00	0	33. 58
50. 00	TOTAL (sum of lines 1 thru 49)		-35, 968, 266	1			50.00
	(Transfer to Worksheet A,						
(1) De	<u> column 6, line 200.)</u> scription - all chapter referer	L	umn nertain to	CMS Pub 15_1			

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

Health Financial Systems	HENDRI CKS REG	ONAL HEALTH	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 3:0	
			Expense Classification o			
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1.00	2. 00	3. 00	4. 00	5. 00	

- 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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: Provider CCN: 15-0005

						10 12/31/2020	7/30/2021 3:0	06 pm
	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	4. 00	EMPLOYEE BENEFITS DEPARTMENT	617, 748	2, 502	615, 246	206, 300	3, 740	1. 00
2.00	5. 00	ADMINISTRATIVE & GENERAL	1, 506, 340	710, 500	795, 840	206, 300	3, 998	2. 00
3.00	13. 00	NURSING ADMINISTRATION	178, 127	53, 954	124, 173	206, 300	611	3. 00
4.00	0.00		0		0	0	0	4. 00
5.00	30.00	ADULTS & PEDIATRICS	3, 611, 037	3, 527, 304	83, 733	174, 600	423	5. 00
6.00		INTENSIVE CARE UNIT	350, 053				115	6. 00
7.00		OPERATING ROOM	372			206, 300	0	7. 00
8.00		ANESTHESI OLOGY	6, 623, 485	6, 623, 485			0	1
9. 00		RADI OLOGY-DI AGNOSTI C	67, 916				0	
10.00		LABORATORY	89, 362				0	
11. 00		RESPI RATORY THERAPY	0	0.,000	0		0	
12. 00		PHYSI CAL THERAPY	705, 687	705, 687		206, 300	0	12. 00
13. 00		ELECTROCARDI OLOGY	154, 990				0	
14. 00		EMERGENCY	1, 243, 783				230	
200.00	71.00	EMERGENOT	15, 148, 900			l	9, 117	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
	III.St. // Line #	I denti fi er			Memberships &		of Malpractice	
		1 46.11.11.61		Li mi t	Conti nui ng	Share of col.	Insurance	
				Li iiii t	Education	12	Trisul direc	
	1. 00	2.00	8. 00	9. 00	12. 00	13.00	14. 00	
1. 00		EMPLOYEE BENEFITS DEPARTMENT	370, 943	18, 547			0	1. 00
2.00		ADMINISTRATIVE & GENERAL	396, 532				0	
3.00		NURSING ADMINISTRATION	60, 601	3, 030			0	
4. 00	0.00		0		0		0	
5. 00		ADULTS & PEDIATRICS	35, 508	1, 775	0	0	0	5. 00
6.00		INTENSIVE CARE UNIT	12, 910			0	0	
7. 00		OPERATING ROOM	0			0	0	
8.00		ANESTHESI OLOGY	0	i o			0	
9. 00		RADI OLOGY-DI AGNOSTI C	0	1	0		0	9. 00
10. 00		LABORATORY	0	0	0	0	0	10.00
11. 00		RESPI RATORY THERAPY	0	0	0	0	0	11. 00
12. 00		PHYSI CAL THERAPY	0		0	0	0	
13. 00		ELECTROCARDI OLOGY	ا م		0	0	0	13. 00
14. 00		EMERGENCY	22, 812	1, 141	_	0	o o	
200.00	71.00	EMERGENOT	899, 306			0	_	200.00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200.00
		I denti fi er	Component	Limit	Di sal I owance	/ raj do tinorre		
			Share of col.					
			14					
	1.00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	0	370, 943	244, 303	246, 805		1. 00
2.00	5. 00	ADMINISTRATIVE & GENERAL	0	396, 532	399, 308	1, 109, 808		2. 00
3.00	13. 00	NURSING ADMINISTRATION	0	60, 601	63, 572	117, 526		3. 00
4.00	0.00		0	l c	0	0		4. 00
5.00	30.00	ADULTS & PEDIATRICS	0	35, 508	48, 225	3, 575, 529		5. 00
6.00	31.00	INTENSIVE CARE UNIT	0	12, 910	10, 490			6. 00
7. 00		OPERATING ROOM	0		0	372		7. 00
8.00		ANESTHESI OLOGY	0	C	0	ŀ		8. 00
9.00		RADI OLOGY-DI AGNOSTI C	0	C	0			9. 00
10.00		LABORATORY	0		0	89, 362		10. 00
11. 00		RESPI RATORY THERAPY	0		0	1		11. 00
12. 00		PHYSI CAL THERAPY	l o		0	705, 687		12. 00
13. 00		ELECTROCARDI OLOGY	0		0			13. 00
14. 00		EMERGENCY	0		_	1, 220, 971		14. 00
200.00	11.00		0	,,	· ·			200.00
200.00	ı	!	, ,	1 5,7,300	, , , , , , , , ,	1, 2., , , , , ,	ı	

In Lieu of Form CMS-2552-10 Health Financial Systems HENDRICKS REGIONAL HEALTH COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0005 Peri od: Worksheet B From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/30/2021 3:06 pm CAPI TAL RELATED COSTS ADMI NI STRATI VE Cost Center Description Net Expenses NEW BLDG & **EMPLOYEE** Subtotal FLXT for Cost BENEFITS & GENERAL DEPARTMENT Allocation (from Wkst A col. 7) 1.00 4.00 5. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 25, 675, 307 25, 675, 307 1 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 25, 959, 174 316, 428 26, 275, 602 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 52, 481, 345 1, 764, 461 2, 332, 769 56, 578, 575 56, 578, 575 5.00 00700 OPERATION OF PLANT 11, 352, 225 3, 313, 886 15, 139, 967 7.00 7 00 473, 856 3, 113, 761 00800 LAUNDRY & LINEN SERVICE 8.00 509, 118 271, 061 63, 744 843, 923 173, 565 8.00 9.00 00900 HOUSEKEEPI NG 3, 635, 581 127, 124 466, 156 4, 228, 861 869, 729 9.00 10.00 01000 DI ETARY 750, 316 477, 377 121,065 1, 348, 758 277, 392 10.00 01100 CAFETERI A 84, 778 219, 675 1, 339, 677 1, 644, 130 338, 140 11 00 11 00 13.00 01300 NURSING ADMINISTRATION 9, 394, 607 246, 753 1, 022, 360 10, 663, 720 2, 193, 154 13.00 01400 CENTRAL SERVICES & SUPPLY 2, 668, 515 460, 821 190, 667 3, 320, 003 682, 808 14.00 14.00 01500 PHARMACY 251, 968 440, 826 4, 205, 359 864, 895 15.00 15.00 3, 512, 565 01600 MEDICAL RECORDS & LIBRARY 1, 366, 030 154, 680 16.00 110, 229 1, 630, 939 335, 427 16.00 17.00 01700 SOCIAL SERVICE 2, 180, 050 330, 665 2, 510, 715 516, 366 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 12, 457, 285 2, 164, 983 2, 391, 521 3, 499, 141 30.00 03000 ADULTS & PEDIATRICS 17, 013, 789 30.00 31.00 03100 INTENSIVE CARE UNIT 3, 698, 419 251, 085 535.013 4.484.517 922, 308 31.00 43.00 04300 NURSERY 1, 647, 566 47, 533 240, 276 1, 935, 375 398, 039 43.00 44.00 04400 SKILLED NURSING FACILITY Ω 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 683, 812 640, 065 445, 532 4, 769, 409 980, 901 50.00 05001 ENDOSCOPY 1, 518, 298 443, 010 170, 543 2, 131, 851 438, 447 50.01 50.01 51.00 05100 RECOVERY ROOM 1, 698, 730 781, 124 237, 803 2, 717, 657 558, 927 51.00 05200 DELIVERY ROOM & LABOR ROOM 3, 223, 555 52.00 312, 980 465, 217 4, 001, 752 823, 020 52.00 53.00 05300 ANESTHESI OLOGY 988, 312 1, 147, 909 2, 136, 221 439, 346 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 076, 037 1, 055, 813 10, 267, 891 2, 111, 746 54.00 8, 136, 041 54.00 54.01 05401 RADI ATI ON-ONCOLOGY 16, 787, 978 478, 118 230, 187 17, 496, 283 3, 598, 373 54.01 56.00 05600 RADI OI SOTOPE C Ω 56.00 05601 NUCLEAR MEDICINE 368, 700 15,018 34, 718 418, 436 86,058 56.01 56, 01 05900 CARDIAC CATHETERIZATION 59.00 1, 586, 958 271, 659 97, 326 1, 955, 943 402, 269 59.00 06000 LABORATORY 2, 175, 158 9, 652, 872 350, 367 572.981 10, 576, 220 60.00 60.00 06400 I NTRAVENOUS THERAPY 64.00 1, 631, 653 94, 809 169, 818 1, 896, 280 389, 998 64.00 06500 RESPIRATORY THERAPY 413, 717 3, 855, 722 792, 987 65.00 3, 115, 461 326, 544 65.00 06600 PHYSI CAL THERAPY 7, 233, 082 696, 802 1, 024, 949 8, 954, 833 1, 841, 696 66.00 66.00 06700 OCCUPATIONAL THERAPY 518, 982 88, 783 204, 920 812, 685 167, 141 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 365, 987 67, 680 57,016 490, 683 100, 916 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 019, 506 314, 319 150, 385 1, 484, 210 305, 250 69.00 06901 CARDI AC REHAB 609 695 93.898 173, 422 69 01 139, 634 843 227 69 01 07000 ELECTROENCEPHALOGRAPHY 70.00 142,032 76, 428 20, 834 239, 294 49, 214 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS C 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 11, 048, 726 0 0 11, 048, 726 2, 272, 336 72.00 07300 DRUGS CHARGED TO PATIENTS 11, 576, 785 2, 380, 939 73 00 11, 576, 785 O 73 00 73.01 07301 ULTRA SOUND 678, 537 19, 435 103, 056 801, 028 164, 743 73.01 07400 RENAL DIALYSIS 329, 255 329, 299 74.00 67, 725 74.00 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 4 842 026 512, 941 263, 325 5 618 292 1, 155, 486

09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM_OF_LINES 1 through 117) 256, 369, 300 17, 743, 864 16, 898, 784 239, 061, 039 37, 530, 252 118. 00 118.00 NONREI MBURSABLE COST CENTERS 8, 039, 687 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 63, 499, 962 6,007,913 77, 547, 562 15, 948, 723 192. 00 192. 01 19201 HEALTH TRACKS 980, 655 192. 01 3, 853, 098 380,004 535, 111 4. 768. 213 2, 291, 982 194.00 07950 PRIMARY CARE CLINIC 988, 068 155, 118 3, 435, 168 706, 494 194. 00 194. 01 07951 PARTNERS IN CARE -16, 799 -16, 799 0 194. 01 194. 02 07952 OCCUPATIONAL MEDICINE 949, 834 123, 932 71, 518 1, 145, 284 235, 545 194. 02 194. 03 07953 FOUNDATION 22, 085 25, 294 218, 495 44, 937 194. 03 171, 116 194.04 07954 SCHOOL & TOWN CLINICS 2, 255, 562 32, 714 250, 121 2, 538, 397 522, 059 194. 04 194.05 07955 MANAGED FACILITY 596, 995 138, 357 194. 05 75, 736 672, 731 194. 06 07956 RENTAL PROPERTIES 33, 784 194. 06 164, 235 32 164.267 194.07 07957 SNF NON CERTIFIED 1, 527, 624 376, 727 224, 201 2, 128, 552 437, 769 194. 07 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201.00 331, 662, 909 25, 675, 307 56, 578, 575 202. 00 202.00 TOTAL (sum lines 118 through 201) 331, 662, 909 26, 275, 602

6, 984, 537

989, 036

1, 116, 108

9, 089, 681

1, 869, 429

91.00

91.00

09100 EMERGENCY

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared: | 7/30/2021 3:06 pm

				''	0 12/31/2020	7/30/2021 3:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	· ·		LINEN SERVICE				
		7.00	8. 00	9. 00	10. 00	11. 00	
	NERAL SERVICE COST CENTERS	T		T			
	0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	D500 ADMINISTRATIVE & GENERAL	40.050.700					5. 00
	0700 OPERATION OF PLANT	18, 253, 728	4 047 400				7. 00
	0800 LAUNDRY & LINEN SERVICE	0	1, 017, 488				8. 00
	1990 HOUSEKEEPI NG	228, 864	0	-,,			9.00
	000 DI ETARY	897, 875	0	,		l	10.00
	100 CAFETERI A	159, 454	0	56, 782	0	2, 198, 506	
	300 NURSI NG ADMI NI STRATI ON	464, 106	0	,	0	161, 152	
	400 CENTRAL SERVICES & SUPPLY	830, 395	464		0	52, 627	
	500 PHARMACY	473, 914	999		0	70, 069	1
	600 MEDI CAL RECORDS & LI BRARY	290, 930	0	-,	0	1,	
	700 SOCIAL SERVICE	0	0	3, 340	0	64, 715	17. 00
	PATIENT ROUTINE SERVICE COST CENTERS	2.7/0.420	250 242	041 010	1 757 475	225 540	20.00
	3000 ADULTS & PEDIATRICS	3, 760, 438	258, 343				1
	3100 INTENSIVE CARE UNIT	472, 252	70, 443				
	1300 NURSERY	89, 402	27, 137			46, 351	
	400 SKILLED NURSING FACILITY CILLARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
	5000 OPERATING ROOM	1, 203, 866	52, 817	163, 665	0	92, 860	50.00
	5001 ENDOSCOPY	833, 235	52, 617 51, 988		0		1
	5100 RECOVERY ROOM		46, 152		0	l	1
	5200 DELIVERY ROOM & LABOR ROOM	1, 469, 176	•		0	1	1
	•	588, 667	52, 540		0	89, 745	
	3300 ANESTHESI OLOGY	0	112 522	0,000	0	57, 629	
	8400 RADI OLOGY-DI AGNOSTI C	1, 117, 895	112, 533		0	192, 206	
	6401 RADI ATI ON-ONCOLOGY	0	6, 923		0		
	6600 RADI OI SOTOPE	0	0	0	0	0	56.00
	MUCLEAR MEDICINE	28, 246	0	10, 020	0	6, 211	
	5900 CARDI AC CATHETERI ZATI ON	510, 950	0	0	0	19, 223	
	0000 LABORATORY	483, 562	7, 181		0	144, 769	1
	0400 I NTRAVENOUS THERAPY	178, 321	12		0	26, 314	
	5500 RESPIRATORY THERAPY	549, 809	0		0	82, 725	
	600 PHYSI CAL THERAPY	560, 100	67, 038		0	196, 638	
	0700 OCCUPATI ONAL THERAPY	23, 208	0		0	15, 913	
	800 SPEECH PATHOLOGY	127, 295	0	.0,020	0	10, 213	
	9900 ELECTROCARDI OLOGY	591, 187	12, 912		0	44, 341	
	9901 CARDI AC REHAB	158, 436	201		0	17, 278	
	'000 ELECTROENCEPHALOGRAPHY	143, 750	1, 410	46, 761	0	4, 742	1
1	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
	200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
	300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	'301 ULTRA SOUND	36, 554	0	10, 020	0		
	400 RENAL DIALYSIS	0	279	13, 360	0	0	74. 00
	TPATIENT SERVICE COST CENTERS	T		1			
	2000 CLI NI C	0	40, 865		0		90. 00
	2100 EMERGENCY	1, 212, 066	145, 364	397, 471	0	183, 312	
	2200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	PECIAL PURPOSE COST CENTERS	T		T			
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	17, 483, 953	955, 601	4, 338, 786	2, 354, 136	2, 159, 844]118. 00
	NREI MBURSABLE COST CENTERS	T		1	_	_	
	2200 PHYSICIANS' PRIVATE OFFICES	61, 209	31, 738		0		192. 00
	2201 HEALTH TRACKS	0	6, 643		0		192. 01
	950 PRIMARY CARE CLINIC	0	2, 871	30, 061	0		194. 00
	951 PARTNERS IN CARE	0	0	0	0	l	194. 01
	952 OCCUPATIONAL MEDICINE	0	909		0	l	194. 02
	7953 FOUNDATION	0	0	3, 340	0		194. 03
	7954 SCHOOL & TOWN CLINICS	0	316		0	l	194. 04
	955 MANAGED FACILITY	0	0	0	0	l .	194. 05
	7956 RENTAL PROPERTIES	0	0	0	0		
	957 SNF NON CERTIFIED	708, 566	19, 410	0	203, 290	38, 662	194. 07
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	18, 253, 728	1, 017, 488	5, 327, 454	2, 557, 426	2, 198, 506	202. 00

Provider CCN: 15-0005

			To	12/31/2020	Date/Time Pre 7/30/2021 3:0	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	D DIII
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
	12.00	SUPPLY	15.00	LI BRARY	17.00	
GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	13, 518, 873					11. 00 13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	13, 316, 673	4, 979, 820				14. 00
15. 00 01500 PHARMACY	0	4, 7, 7, 020	5, 635, 277			15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	o	O	0	2, 294, 029		16. 00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	3, 095, 136	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 336, 511	0	0	114, 727	1, 293, 114	30. 00
31. 00 03100 I NTENSI VE CARE UNIT	810, 750	0	0	42, 857	228, 826	31.00
43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY	460, 891 0	0	0	28, 266	0	43. 00 44. 00
ANCI LLARY SERVICE COST CENTERS	l U	<u>U</u>	U	<u> </u>	0	44.00
50. 00 05000 OPERATING ROOM	923, 350	4, 979, 820	0	215, 968	1, 222, 001	50.00
50. 01 05001 ENDOSCOPY	311, 598	0	0	42, 278	0	50. 01
51.00 05100 RECOVERY ROOM	403, 776	О	0	41, 152	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	892, 381	0	0	54, 990	0	52. 00
53. 00 05300 ANESTHESI OLOGY	573, 031	0	0	61, 115	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 911, 201	0	0	235, 210	0	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0	0	0	213, 471	0	54. 01
56. 00 05600 RADI OI SOTOPE 56. 01 05601 NUCLEAR MEDI CI NE	61, 763	0	0	22, 161	0	56. 00 56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	191, 140	0	0	77, 956	0	59. 00
60. 00 06000 LABORATORY	171, 140	Ö	0	232, 281	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	o	Ö	0	29, 514	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	822, 571	0	0	61, 067	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	70, 561	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	7, 726	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	7, 148	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	440, 905	0	0	57, 946	0	69.00
69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY	171, 803	0	0	5, 563 2, 138	0	69. 01 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2, 130	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	O	0	66, 071	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	О	5, 635, 277	151, 384	0	73. 00
73. 01 07301 ULTRA SOUND	0	0	0	31, 571	0	73. 01
74. 00 07400 RENAL DIALYSIS	0	0	0	1, 406	0	74. 00
OUTPATIENT SERVICE COST CENTERS		ما		105 250	0	00.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0 1, 822, 763	0	0	105, 258 314, 244	0 351, 195	90. 00 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,022,703	٥	U	314, 244	331, 193	91.00
SPECIAL PURPOSE COST CENTERS						72.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	13, 134, 434	4, 979, 820	5, 635, 277	2, 294, 029	3, 095, 136	118. 00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
192. 01 19201 HEALTH TRACKS	0	0	0	0		192. 01
194. 00 07950 PRI MARY CARE CLINIC	0	0	0	0		194. 00
194. 01 07951 PARTNERS IN CARE 194. 02 07952 OCCUPATIONAL MEDICINE	0	0	0	0		194. 01
194. 02 07952 OCCUPATIONAL MEDICTINE 194. 03 07953 FOUNDATION	0	0	0	0		194. 02 194. 03
194.04 07954 SCHOOL & TOWN CLINICS	0	0	0	0		194. 03
194. 05 07955 MANAGED FACILITY		n	n	ol O		194. 05
194. 06 07956 RENTAL PROPERTIES		ő	Ö	ol		194. 06
194.07 07957 SNF NON CERTIFIED	384, 439	o	0	o		194. 07
200.00 Cross Foot Adjustments		ļ				200. 00
201.00 Negative Cost Centers	0	0	_ 0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	13, 518, 873	4, 979, 820	5, 635, 277	2, 294, 029	3, 095, 136	202. 00

HENDRICKS REGIONAL HEALTH

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

			Fi To	rom 01/01/2020 Part o 12/31/2020 Date/Time Pre 7/30/2021 3:0	
Cost Center Description	Subtotal F	Intern & Residents Cost & Post Stepdown Adjustments	Total	773072021 3.3	JO DIII
	24.00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS					
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVICE INPATI ENT ROUTI NE SERVICE COST CENTERS					1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
30. 00 03000 ADULTS & PEDIATRICS	32, 310, 997	0	32, 310, 997		30. 00
31. 00 03100 I NTENSI VE CARE UNIT	7, 781, 799	0	7, 781, 799		31.00
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY	3, 284, 562 0	0 0	3, 284, 562 0		43. 00 44. 00
ANCILLARY SERVICE COST CENTERS	14 (04 (57	ol	14 (04 (57		F0.00
50.00 05000 OPERATI NG ROOM 50.01 05001 ENDOSCOPY	14, 604, 657 3, 967, 658	0	14, 604, 657 3, 967, 658		50. 00 50. 01
51. 00 05100 RECOVERY ROOM	5, 337, 569	o	5, 337, 569		51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	6, 670, 100	0	6, 670, 100		52. 00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 274, 022 16, 309, 412	0	3, 274, 022 16, 309, 412		53. 00 54. 00
54. 01 05401 RADI ATI ON-ONCOLOGY	21, 497, 115	o	21, 497, 115		54. 01
56. 00 05600 RADI 0I SOTOPE	0	О	0		56. 00
56. 01 05601 NUCLEAR MEDICINE	632, 895	0	632, 895		56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	3, 157, 481 13, 862, 998	0	3, 157, 481 13, 862, 998		59. 00 60. 00
64. 00 06400 I NTRAVENOUS THERAPY	2, 530, 459	0	2, 530, 459		64. 00
65. 00 06500 RESPIRATORY THERAPY	6, 181, 581	0	6, 181, 581		65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	12, 175, 180 1, 076, 774	0	12, 175, 180 1, 076, 774		66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	746, 275	0	746, 275		68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 990, 193	0	2, 990, 193		69. 00
69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 410, 011	0	1, 410, 011 487, 309		69. 01 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	487, 309	0	487, 309		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	13, 387, 133	О	13, 387, 133		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	19, 744, 385	0	19, 744, 385		73. 00
73. 01 07301 ULTRA SOUND 74. 00 07400 RENAL DIALYSIS	1, 060, 524 412, 069	0	1, 060, 524 412, 069		73. 01 74. 00
OUTPATIENT SERVICE COST CENTERS		-1	,		
90. 00 09000 CLI NI C	7, 287, 312	0	7, 287, 312		90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	15, 385, 525	0	15, 385, 525		91. 00 92. 00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	217, 565, 995	0	217, 565, 995		118. 00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	94, 320, 713	0	94, 320, 713		192. 00
192. 01 19201 HEALTH TRACKS	5, 902, 475	o	5, 902, 475		192. 01
194. 00 07950 PRI MARY CARE CLINIC	4, 174, 594	0	4, 174, 594		194. 00
194. 01 07951 PARTNERS IN CARE 194. 02 07952 OCCUPATIONAL MEDICINE	-16, 799 1, 451, 880	0	-16, 799 1, 451, 880		194. 01 194. 02
194. 03 07953 FOUNDATION	266, 772	Ö	266, 772		194. 03
194. 04 07954 SCHOOL & TOWN CLINICS	3, 067, 452	O	3, 067, 452		194. 04
194. 05 07955 MANAGED FACILITY 194. 06 07956 RENTAL PROPERTIES	811, 088 198, 051	0	811, 088 198, 051		194. 05 194. 06
194.00 07936 RENTAL PROPERTIES 194.07 07957 SNF NON CERTIFIED	3, 920, 688	o	3, 920, 688		194. 00
200.00 Cross Foot Adjustments	0	0	0		200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0 331, 662, 909	0	0 331, 662, 909		201. 00 202. 00
202.00 TOTAL (Sum Titles 110 till ough 201)	331, 302, 707	٩	331, 302, 707		1202.00

| Peri od: | Worksheet B | From 01/01/2020 | Part | I | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0005

					To	12/31/2020	Date/Time Prep 7/30/2021 3:00	
				CAPITAL			773072021 3.00	э рііі
		Cost Center Description	Directly	RELATED COSTS NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
		cost denter bescription	Assigned New	FIXT	Subtotal	BENEFITS	& GENERAL	
			Capi tal			DEPARTMENT		
			Related Costs 0	1.00	2A	4. 00	5. 00	
	GENERA	AL SERVICE COST CENTERS		11.00		00	0.00	
1.00		NEW CAP REL COSTS-BLDG & FIXT		24 (422	247 400	04 / 400		1.00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	0	316, 428 1, 764, 461	316, 428 1, 764, 461	316, 428 28, 093	1, 792, 554	4. 00 5. 00
7. 00		OPERATION OF PLANT	Ö	3, 313, 886		5, 707	98, 652	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	271, 061	· ·	768	5, 499	8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	0	127, 124 477, 377		5, 614 1, 458	27, 555 8, 789	9. 00 10. 00
11. 00		CAFETERI A	o	84, 778	·	2, 646	10, 713	11. 00
13. 00		NURSI NG ADMINI STRATI ON	0	246, 753		12, 312	69, 485	13. 00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	460, 821 251, 968		2, 296 5, 309	21, 633 27, 402	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	154, 680		1, 327	10, 627	16. 00
17. 00		SOCI AL SERVI CE	0	0	0	3, 982	16, 360	17. 00
30. 00		ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0	2, 164, 983	2, 164, 983	28, 801	110, 862	30. 00
31. 00		INTENSIVE CARE UNIT	0			6, 443	29, 221	31. 00
43.00		NURSERY	0	47, 533		2, 894	12, 611	43. 00
44. 00		SKILLED NURSING FACILITY _ARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
50. 00		OPERATING ROOM	0	640, 065	640, 065	5, 366	31, 077	50. 00
50. 01	05001	ENDOSCOPY	0	443, 010	443, 010	2, 054	13, 891	50. 01
51.00		RECOVERY ROOM	0	781, 124		2, 864	17, 708	
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	312, 980 0		5, 603 13, 824	26, 075 13, 920	52. 00 53. 00
54.00		RADI OLOGY-DI AGNOSTI C	0	1, 076, 037		12, 715	66, 906	54. 00
54. 01		RADI ATI ON-ONCOLOGY	0	478, 118		2, 772	114, 006	54. 01
56. 00 56. 01		RADI OI SOTOPE NUCLEAR MEDI CI NE	0	0 15, 018		0 418	0 2, 727	56. 00 56. 01
59. 00		CARDI AC CATHETERI ZATI ON	Ö	271, 659		1, 172	12, 745	59. 00
60.00		LABORATORY	0	350, 367		6, 900	68, 915	60.00
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	0	94, 809 326, 544		2, 045 4, 982	12, 356 25, 124	64. 00 65. 00
66. 00		PHYSI CAL THERAPY	o	696, 802		12, 343	58, 350	
67. 00		OCCUPATI ONAL THERAPY	0	204, 920		1, 069	5, 295	67. 00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	67, 680 314, 319		687 1, 811	3, 197 9, 671	68. 00 69. 00
69. 01		CARDI AC REHAB	ő	139, 634		1, 131	5, 494	69. 01
70. 00	1	ELECTROENCEPHALOGRAPHY	0	76, 428		251	1, 559	70. 00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	0	0	1	0	0 71, 993	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0	0	0	0	71, <i>97</i> 3 75, 434	
73. 01		ULTRA SOUND	0	19, 435	19, 435	1, 241	5, 219	
74. 00	07400	RENAL DIALYSIS FIENT SERVICE COST CENTERS	0	0	0	1	2, 146	74. 00
90. 00		CLINIC	0	512, 941	512, 941	3, 171	36, 609	90. 00
91. 00		EMERGENCY	0	989, 036		13, 441	59, 228	
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART) AL PURPOSE COST CENTERS			0			92. 00
118.00	SFECT/	SUBTOTALS (SUM OF LINES 1 through 117)	0	17, 743, 864	17, 743, 864	203, 511	1, 189, 054	118. 00
	NONRE	MBURSABLE COST CENTERS						
		PHYSI CI ANS' PRI VATE OFFI CES HEALTH TRACKS	0	6, 007, 913 380, 004		96, 815	505, 295 31, 070	
		PRIMARY CARE CLINIC	0	988, 068		6, 444 1, 868	22, 384	
194. 01	07951	PARTNERS IN CARE	0	0	0	0	0	194. 01
		OCCUPATIONAL MEDICINE FOUNDATION	0	123, 932		861 305		194. 02 194. 03
		SCHOOL & TOWN CLINICS	0	22, 085 32, 714		3, 012	16, 540	
194. 05	07955	MANAGED FACILITY	0	0		912	4, 384	194. 05
		RENTAL PROPERTIES	0	276 727	1	0 2 700		194. 06
200.00		SNF NON CERTIFIED Cross Foot Adjustments		376, 727	376, 727 0	2, 700	13, 870	194. 07 200. 00
201.00		Negative Cost Centers		0	o	0	0	201. 00
202. 00		TOTAL (sum lines 118 through 201)	0	25, 675, 307	25, 675, 307	316, 428	1, 792, 554	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0005

Peri od: Worksheet B From 01/01/2020 Part II To 12/31/2020 Date/Time Prepared:

7/30/2021 3:06 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A **PLANT** LINEN SERVICE 9.00 10.00 11.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7 00 00700 OPERATION OF PLANT 3, 418, 245 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 277, 328 8.00 00900 HOUSEKEEPI NG 42,858 203, 151 9.00 9.00 10.00 01000 DI ETARY 168, 139 0 1, 274 657, 037 10.00 01100 CAFETERI A 130, 162 11.00 29,860 C 2.165 11.00 13.00 01300 NURSING ADMINISTRATION 86, 910 1, 401 9, 541 13.00 0 14 00 01400 CENTRAL SERVICES & SUPPLY 155, 502 126 3,566 0 3, 116 14.00 01500 PHARMACY 88, 746 4, 148 15 00 0 15.00 272 764 01600 MEDICAL RECORDS & LIBRARY 16.00 54, 480 255 0 1,779 16.00 17.00 01700 SOCIAL SERVICE 127 3,831 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 704, 191 70.418 35, 920 451, 519 19,867 31.00 03100 INTENSIVE CARE UNIT 88, 435 19, 200 13, 628 79, 879 4,827 31.00 73, 411 43.00 43 00 04300 NURSERY 16,742 7, 396 509 2,744 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS 44.00 44.00 0 50.00 05000 OPERATING ROOM 225, 439 14, 396 5, 498 50.00 6, 241 05001 ENDOSCOPY 14, 170 0 50.01 156, 034 4,840 1,855 50.01 0 05100 RECOVERY ROOM 51.00 275. 122 12.579 2.293 2, 404 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 110, 236 14, 320 6, 368 5, 313 52.00 53.00 05300 ANESTHESI OLOGY 255 3, 412 53.00 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 209, 340 30, 672 13, 756 11, 380 54.00 05401 RADI ATI ON-ONCOLOGY 1, 887 54.01 0 5, 222 2, 671 54.01 56.00 05600 RADI 0I S0T0PE 0 0 56.00 C C 05601 NUCLEAR MEDICINE 56. 01 5, 289 382 0 0 0 368 56.01 05900 CARDIAC CATHETERIZATION 59.00 95.682 1.138 59.00 0 06000 LABORATORY 90.553 60.00 1, 957 9, 298 8, 571 60.00 64.00 06400 I NTRAVENOUS THERAPY 33, 393 382 1,558 64.00 06500 RESPIRATORY THERAPY 65.00 102, 959 637 0 4,898 65.00 66 00 06600 PHYSI CAL THERAPY 104 886 18, 272 18 468 11, 642 66 00 06700 OCCUPATI ONAL THERAPY 67.00 4,346 1, 911 942 67.00 06800 SPEECH PATHOLOGY 23, 838 382 0 0 0 0 0 0 605 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 110, 707 3, 519 2.038 2.625 69.00 06901 CARDI AC REHAB 69.01 29,669 55 1, 528 1, 023 69.01 07000 ELECTROENCEPHALOGRAPHY 1, 783 70.00 26, 919 384 281 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 C 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 Ω 0 Ω 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 C 0 0 73.00 07301 ULTRA SOUND 6,845 0 983 73.01 73.01 C 382 74.00 07400 RENAL DIALYSIS 509 o 0 74.00 76 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 11, 138 14.010 0 0 90.00 91.00 09100 EMERGENCY 226, 975 39, 621 15, 157 0 10, 853 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 274, 095 260, 461 165, 451 604, 809 127, 873 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 11, 462 27, 893 8.650 192. 01 19201 HEALTH TRACKS 0 1.811 5.604 0 0 192. 01 194.00 07950 PRIMARY CARE CLINIC 0 1, 146 0 0 194.00 782 0 194. 01 07951 PARTNERS IN CARE 0 0 0 194. 01 0 194. 02 07952 OCCUPATIONAL MEDICINE 0 194. 02 248 2,675 194. 03 07953 FOUNDATI ON 0 194. 03 r 127 0 194.04 07954 SCHOOL & TOWN CLINICS 0 0 0 194. 04 86 255 194.05 07955 MANAGED FACILITY 0 0 0 194. 05 C 194. 06 07956 RENTAL PROPERTIES 0 0 194, 06 194. 07 07957 SNF NON CERTIFIED 132,688 5, 290 0 52, 228 2, 289 194. 07 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00

3, 418, 245

277, 328

203, 151

657, 037

130, 162 202. 00

TOTAL (sum lines 118 through 201)

202.00

Provider CCN: 15-0005

| Peri od: | Worksheet B | From 01/01/2020 | Part | I | To 12/31/2020 | Date/Time Prepared:

Cost Center Description				To	12/31/2020	Date/Time Pre 7/30/2021 3:0	
SURPEY 11 MANY 11 MANY 11 MANY 11 MANY 10	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		O PIII
		ADMI NI STRATI ON					
GINERAL STRVICE COST CENTERS 1 00 00100 DINCOVER BINET IS DEFARMENT		12.00		15.00		17.00	
0.00 0.00	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
0.000 CONTROL CONTRO							1.00
0.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000							•
0.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.000000 0.00000000	5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
9. 00 00900 MUSERIEP INS	7.00 O0700 OPERATION OF PLANT						7. 00
10.00 10000 DICLARY							•
11.00 1100 (CAFETERIA 1.100 13.00 1300 (MIRS) MIRS MA MINISTRATION 426, 402 14.00							1
13.00 01300 NURSIN SAMIN ISTRATION 426,402 13.00 15.00 1							•
14.00 01400 PARAMACY 0 047,000 11,000 15,00 16.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 22,300 17.		424 402					•
15. 00 01500 PHARMARCY 0 0 378,609 16. 00 17. 00		1	647 060				•
16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 223, 148 16.00 17.00 1700 1700 010 0 0 0 24.300 17.00 1700 010 0 0 0 0 0 0 24.300 17.00 1700 0100 000 011, 18 PERIOLE COST CENTERS		1	017,000	378, 609			•
INPATI ENT ROUTINE SERVICE COST CENTERS 105, 236		0	ō		223, 148		•
30.00	17. 00 01700 SOCIAL SERVICE	0	0	0	0	24, 300	17. 00
31 0.0 03100 INTENSIVE CARE UNIT 25, 572 0 0 4, 171 1,797 31, 00 43.0 04300 MURSERY 14, 527 0 0 0 0 0 0 0 44.0		,					
43. 00 04300 NURSERY 14, 537 0 0 2, 751 0 43, 00 0 0 0 0 0 0 0 0 0		1	-				1
A4. 00 O4-400 SKILLED NURSING FACILITY O O O O O O O O O		1	ĭ	-		· ·	
ANCILLARY SERVICE COST CENTERS		1	-		2, /51		•
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50.01		29, 124	647, 060	0	21, 019	9, 594	50.00
S2.00 0S200 DELLUYERY ROOM & LABOR ROOM 28, 147 0 0 5, 352 0 52, 00 53.00 0S300 ANESTHESI DLOGY 18, 074 0 0 5, 948 0 53.00 53.00 0S300 ANESTHESI DLOGY 0 0 0 0 22, 892 0 54.00 54.01 0S401 ROAD ROAD LOCY-DI ACNOSTI C 60, 282 0 0 0 0 22, 892 0 54.01 54.01 54.01 ROAD			0	0			ł
18.0 05300 ABSTHESI OLOGY 18.074 0 0 5.948 0 53.0 054.00 54.00 54.00 63.00 ABJ OLOGY 16.00 22.892 0 54.00 54.00 05400 RADIO NATION 17.00 0 0 0 0 0 0 0 0 0	51.00 05100 RECOVERY ROOM	12, 736	О	0	4, 005	0	51. 00
S4-00 05400 RADIOLOGY-DIAGNOSTIC 60, 282 0 0 22, 892 0 54, 00	52.00 05200 DELIVERY ROOM & LABOR ROOM	28, 147	O	0	5, 352	0	52. 00
10 05401 RADI ATION-ONCOLOGY		1	0	0			•
56. 00 05.00 RADIO I SOTOPE 0 0 0 0 0 0 56. 00		1	0	-			•
55.01 05601 NUCLEAR MEDICINE 1,948 0 0 2,157 0 56.01		0	0	0	20, 776		•
59.00 05900 CARDIA C CATHETERI ZATION 6,029 0 0 7,587 0 59.00		1 0/8	0	0	2 157	-	
60.0 06.000 06.		1	0	0			
64.00 06400 INTRAVENOUS THERAPY 0 0 0 2,872 0 64.00 65.00 06500 RESPIRATORY THERAPY 25,945 0 0 0 5,943 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 6,867 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 752 0 67.00 68.00 06800 SPECET PATHOLOGY 0 0 0 0 696 0 68.00 69.00 06900 ELECTROCARDI OLOGY 13,907 0 0 5,440 0 69.00 69.01 06901 CARDIAC REHAB 5,419 0 0 0 541 0 69.00 71.00 07000 ELECTROCARDI OLOGY 0 0 0 541 0 69.00 71.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 541 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 543 0 70.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 6,430 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 6,430 0 73.00 73.01 07301 DRUGS CHARGED TO PATI ENTS 0 0 0 378,609 14,733 0 73.00 74.00 07400 RENAL DI LALYSIS 0 0 0 0 3,073 0 73.00 74.00 07400 RENAL DI LALYSIS 0 0 0 0 0 30,466 2,757 91.00 79.00 09000 CLI NIC 0 0 0 0 0 0 0 0 79.00 09000 CLI NIC 0 0 0 0 0 0 0 79.00 09000 CLI NIC 0 0 0 0 0 0 0 79.00 09000 CLI NIC 0 0 0 0 0 0 0 79.00 09000 0 0 0 0 0 0 0		1	Ö	0			•
66.00 06600 PHYSI CAL THERAPY 0 0 0 0 6,867 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 752 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 696 0 68.00 69.00 06900 ELECTROCARDI OLOGY 13,907 0 0 5,640 0 69.00 70.00 07000 CARDIAC REHAB 5,419 0 0 5,411 0 69.01 71.00 07000 ELECTROENCEPHALGGRAPHY 5,419 0 0 0 208 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 6,430 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 378,609 14,733 0 73.00 73.01 07301 IUTRA SOUND 0 0 0 378,609 14,733 0 73.00 74.00 07400 RENAL DIALYSI S 0 0 0 0 137 0 74.00 74.00 07400 RENAL DIALYSI S 0 0 0 0 10,244 0 90.00 79.00 09000 CLINI C 0 0 0 10,244 0 90.00 79.00 09000 CLINI C 57,492 0 0 30,466 2,757 91.00 79.00 09000 DRERGENCY 57,492 0 0 378,609 223,148 24,300 118.00 79.00 09000 CLINIC SUBSTINICT PART SUBSTIN		0	ō	0			•
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 752 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 13, 907 0 0 0 696 0 68. 00 69. 01 06901 CARDI AC REHAB 5, 419 0 0 5, 640 0 69. 00 69. 01 06901 CARDI AC REHAB 5, 419 0 0 5, 640 0 69. 00 70. 00 70000 ELECTROCARDI OLOGY 70. 00 0 0 0 5, 640 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 378,609 14,733 0 73. 01 73. 01 07301 IU.TRA SOUND 0 0 0 0 378,609 14,733 0 73. 01 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 137 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 0 0 0 75. 492 0 0 0 0 0 0 0 0 0	65. 00 06500 RESPIRATORY THERAPY	25, 945	o	0	5, 943	0	65. 00
68.00 06800 SPECH PATHOLOGY 0 0 0 666 0 68.00 69.00 06900 ELECTROCARDIOLOGY 13,907 0 0 0 5,640 0 69.00 69.00 69.00 10.00 10.00 10.00 15.41 0 69.00 69.00 10.		0	0	0	6, 867		66. 00
69.00 06900 ELECTROCARDI OLOGY 13,907 0 0 5,640 0 69,00 69.01 06901 CARDI AC REHAB 5,419 0 0 5411 0 69,01 70.00 07000 ELECTROCENCEPHALOGRAPHY 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 6,430 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 6,430 0 73.01 07301 ULTRA SOUND 0 0 0 0 3,073 0 73.01 07301 ULTRA SOUND 0 0 0 0 1377 0 74.00 07400 RENAL DI ALYSIS 0 0 0 0 1377 0 74.00 07400 RENAL DI ALYSIS 0 0 0 0 1377 0 75.00 09100 EMERGENCY 57,492 0 0 30,466 2,757 91.00 79.00 09200 DSSERVATI ON BEDS (NON-DISTINCT PART) 57,492 0 0 30,466 2,757 91.00 79.00 09200 DSSERVATI ON BEDS (NON-DISTINCT PART) 57,492 0 0 378,609 223,148 24,300 79.00 09200 DSSERVATI ON BEDS (NON-DISTINCT PART) 70.00 70.		0	0	0			•
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70. 00 07000 LLECTROENCEPHALOGRAPHY 0 0 0 0 208 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 6.430 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENT 0 0 0 378,609 14,733 0 73. 00 73. 01 07301 ULTRA SOUND 0 0 0 0 3,073 0 73. 01 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 3,073 0 74. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 10,244 0 90. 00 90. 00 09000 CLINI C 0 0 0 0 10,244 0 90. 00 91. 00 09100 EMERGENCY 57,492 0 0 0 30,466 2,757 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 92. 00 SUBTOTALS (SUM OF LINES 1 through 117) 414,276 647,060 378,609 223,148 24,300 118. 00 18. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 192. 01 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 194. 00 07950 PRI MARY CARE CLINI C 0 0 0 0 0 0 194. 01 07951 PARTIBERS IN CARE 0 0 0 0 0 0 194. 02 07952 OCUPATIONAL MEDI CINE 0 0 0 0 0 194. 03 07953 FOUNDATI ON 0 0 0 0 0 194. 04 07954 SCHOOL & TOWN CLINI CS 0 0 0 0 0 194. 05 07955 NANAGED FACILITY 0 0 0 0 0 194. 06 07955 RENTAL PROPERTIES 0 0 0 0 0 194. 06 07955 RENTAL PROPERTIES 0 0 0 0 0 194. 07 07957 SNF NON CERT IF IED 12, 126 0 0 0 0 194. 07 07957 SNF NON CERT IF IED 12, 126 0 0 0 0 194. 07 07957 SNF NON CERT IF IED 12, 126 0 0 0 0 194. 07 07957 SNF NON CERT IF IED 12, 126 0 0 0 0 194. 07 07957 SNF NON CERT IF IED 12, 126 0 0 0 0 194. 07 07957 SNF NON CERT IF IED 12, 126 0 0 0 0 194. 00 00 0 0 0 0 194. 00 00 0 0 0 0 194. 00 00 0 0 0 194. 00			0	0		-	•
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 71. 00 72. 00 72. 00 72. 00 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 6, 430 0 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 378,609 14, 733 0 73. 01 73. 01 07301 UITRA SOUND 0 0 0 0 0 3,073 0 73. 01 74. 00 07400 RENAL DIALYSIS 0 0 0 0 13.7 0 74. 00 0 0 0 0 13.7 0 74. 00 00 0 0 0 0 0 0 0		5,419	0	0			•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 6,430 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 378,609 14,733 0 73. 00 73. 01 07301 ULTRA SOUND 0 0 0 0 0 3.073 0 73. 01 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 137 0 74. 00 0000 CLI NIC 0 0 0 0 0 0 0 0 0			0	0	200		•
73. 01 07301 ULTRA SOUND 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 137 0 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 137 0 74. 00 074. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 137 0 0 74. 00 074.		0	ō	0	6, 430		•
74.00		0	О	378, 609		0	73. 00
90. 00	73.01 07301 ULTRA SOUND	0	0	0	3, 073		73. 01
90. 00		0	0	0	137	0	74. 00
91. 00			ما		10 244	-	00.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 SUBTOTALS (SUM OF LINES 1 through 117) 414, 276 647, 060 378, 609 223, 148 24, 300 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 0 192. 01 192. 01 19201 HEALTH TRACKS 0 0 0 0 0 0 0 192. 01 194. 00 194. 00 194. 01 194. 01 194. 01 194. 02 194. 02 194. 02 194. 02 194. 03 195. 07952 OCCUPATI ONAL MEDI CI NE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0			
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 414, 276 647, 060 378, 609 223, 148 24, 300 18. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 192. 00 192. 00 1920 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 192. 01 1920 HEALTH TRACKS 0 0 0 0 0 192. 01 194. 00 195. 01 195		37, 492	U	U	30, 400	2, 737	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 414,276 647,060 378,609 223,148 24,300 118.00							72.00
192. 00 192.01 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 192. 01 194. 00 195. 01 194. 00 195. 01 195. 01 195. 01 196. 00 197. 01 197. 00 198. 01 199		414, 276	647, 060	378, 609	223, 148	24, 300	118. 00
192. 01 19201 HEALTH TRACKS 194. 00 07950 PRIMARY CARE CLINIC 194. 01 07951 PARTNERS IN CARE 194. 02 07952 OCCUPATIONAL MEDICINE 194. 03 07953 FOUNDATION 194. 04 07954 SCHOOL & TOWN CLINICS 194. 05 07955 MANAGED FACILITY 194. 06 07956 RENTAL PROPERTIES 194. 07 07957 SNF NON CERTIFIED 194. 07 07957 SNF NON CERTIFIED 105. 00 0 0 0 0 0 194. 07 07 07 0 0 0 0 0 194. 07 07 07 0 0 0 0 0 0 194. 07 07 07 0 0 0 0 0 0 0 194. 07 07 07 0 0 0 0 0 0 194. 07 07 07 07 0 0 0 0 0 0 0 194. 07 07 07 07 07 0 0 0 0 0 0 194. 07 07 07 07 07 07 07 07 07 07 07 07 07							
194. 00 07950 PRI MARY CARE CLINIC 0 0 0 194. 00 194. 01 194. 01 194. 02 194. 02 194. 02 194. 03 194. 04 194. 05 194. 07 1975 194. 07 1975 194. 07 1975 194. 07 1975 1		1	0	-	-1		
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194. 03 07953 FOUNDATION 0 0 0 0 194. 03 194. 04 07954 SCHOOL & TOWN CLINICS 0 0 0 0 0 194. 04 194. 05 194. 06 07956 RENTAL PROPERTIES 0 0 0 0 0 0 194. 06 194. 07 07957 SNF NON CERTIFIED 12, 126 0 0 0 0 194. 06 194. 07 07957 SNF NON CERTIFIED 12, 126 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 12, 126 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 12, 126 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 0 12, 126 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 0 12, 126 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 0 12, 126 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 0 12, 126 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 0 12, 126 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 0 12, 126 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 0 12, 126 0 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 0 12, 126 0 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 0 12, 126 0 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 0 12, 126 0 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 0 12, 126 0 0 0 0 0 0 0 194. 07 07957 SNF NON CERTIFIED 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0	0		
194. 04 07954 SCHOOL & TOWN CLINICS		0	0	0	0		1
194. 05 07955 MANAGED FACILITY 0 0 0 0 0 194. 05 194. 06 07956 RENTAL PROPERTIES 0 0 0 0 0 194. 06 194. 07 07957 SNF NON CERTIFIED 12, 126 0 0 0 0 194. 07 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 201. 00			0	0	0		
194. 06 07956 RENTAL PROPERTIES 0 0 0 0 194. 06 194. 07 07957 SNF NON CERTIFIED 12, 126 0 0 0 0 194. 07 200. 00 Cross Foot Adjustments 200. 00 0 0 0 0 0 0 0 201. 00			ol	o	ol		1
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0		0	o	0	o		1
201.00 Negative Cost Centers 0 0 0 0 201.00		12, 126	o	0	o	0	
202.00 TOTAL (Sum lines 118 through 201) 426,402 647,060 378,609 223,148 24,300 202.00			0	0	0		
	ZUZ. UU TUTAL (SUIII TINES TI8 ENFOUGH 201)	426, 402	047, 060	3/8,609	223, 148	24, 300	J2U2. UU

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS In Lieu of Form CMS-2552-10 HENDRICKS REGIONAL HEALTH Peri od: Worksheet B From 01/01/2020 Part II To 12/31/2020 Date/Time Prepared: 7/30/2021 3:06 pm Provider CCN: 15-0005 Cost Center Description Subtotal Total Intern & Residents Cost

		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
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00 00500 ADMINISTRATIVE & GENERAL				5. 00
7.00 00700 OPERATION OF PLANT				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00 00900 HOUSEKEEPI NG				9. 00
10. 00 01000 DI ETARY				10. 00
11. 00 01100 CAFETERI A				11. 00
13.00 O1300 NURSING ADMINISTRATION				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00 01500 PHARMACY				15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY				16.00
17. 00 01700 SOCI AL SERVI CE				17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	2 712 115	ما	2 712 115	20.00
30. 00 03000 ADULTS & PEDI ATRI CS	3, 713, 115	0	3, 713, 115	30.00
31. 00 03100 NTENSI VE CARE UNI T 43. 00 04300 NURSERY	524, 258 181, 128	0	524, 258 181, 128	31. 00 43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	101, 120	0	101, 120	44.00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	44.00
50. 00 05000 OPERATING ROOM	1, 634, 879	O	1, 634, 879	50.00
50. 01 05001 ENDOSCOPY	649, 797	ő	649, 797	50. 01
51. 00 05100 RECOVERY ROOM	1, 110, 835	ő	1, 110, 835	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	514, 394	ol	514, 394	52. 00
53. 00 05300 ANESTHESI OLOGY	55, 433	o	55, 433	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 503, 980	O	1, 503, 980	54.00
54. O1 05401 RADI ATI ON-ONCOLOGY	625, 452	o	625, 452	54. 01
56. 00 05600 RADI OI SOTOPE	0	0	0	56. 00
56. 01 05601 NUCLEAR MEDICINE	28, 307	O	28, 307	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	396, 012	0	396, 012	59. 00
60. 00 06000 LABORATORY	559, 168	0	559, 168	60.00
64. 00 06400 I NTRAVENOUS THERAPY	147, 418	0	147, 418	64. 00
65. 00 06500 RESPI RATORY THERAPY	497, 032	0	497, 032	65. 00
66. 00 06600 PHYSI CAL THERAPY	927, 630	0	927, 630	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	219, 235	0	219, 235	67. 00
68. 00 06800 SPEECH PATHOLOGY	97, 085	0	97, 085	68. 00
69. 00 06900 ELECTROCARDI OLOGY	464, 237	0	464, 237	69. 00
69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY	184, 494	0	184, 494	69. 01 70. 00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	107, 813	0	107, 813 0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	78, 423	0	78, 423	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	468, 776	0	468, 776	73.00
73. 01 07301 ULTRA SOUND	37, 178	o	37, 178	73. 00
74. 00 07400 RENAL DI ALYSI S	2, 869	ő	2, 869	74.00
OUTPATIENT SERVICE COST CENTERS	2/00/	<u> </u>	2,007	7 00
90. 00 09000 CLI NI C	588, 113	0	588, 113	90.00
91. 00 09100 EMERGENCY	1, 445, 026	O	1, 445, 026	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	16, 762, 087	0	16, 762, 087	118. 00
NONREI MBURSABLE COST CENTERS				
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	6, 658, 028	0	6, 658, 028	192. 00
192. 01 19201 HEALTH TRACKS	424, 933	0	424, 933	192. 01
194. 00 07950 PRIMARY CARE CLINIC	1, 014, 248	0	1, 014, 248	194. 00
194. 01 07951 PARTNERS IN CARE	0	0	0	194. 01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	135, 179	0	135, 179	194. 02
194. 03 07953 FOUNDATION	23, 941	0	23, 941	194. 03
194.04 07954 SCHOOL & TOWN CLINICS	52, 607	O	52, 607	194. 04
194. 05 07955 MANAGED FACILITY 194. 06 07956 RENTAL PROPERTIES	5, 296	O O	5, 296 1, 070	194. 05 194. 06
194.06 07956 RENTAL PROPERTIES 194.07 07957 SNF NON CERTIFIED	1, 070 597, 918		597, 918	194. 06
200.00 Cross Foot Adjustments	597, 918		597, 918	200. 00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	25, 675, 307	ő	25, 675, 307	202. 00
, , , , , , , , , , , , , , , , , , , ,		-1		

				1	o 12/31/2020	Date/lime Pre 7/30/2021 3:0	
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SOUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		J Pill
		1. 00	4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	900, 991					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	11, 104	155, 496, 357				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	61, 918	13, 805, 081	-56, 578, 575	275, 101, 133		5. 00
7.00	00700 OPERATION OF PLANT	116, 290	2, 804, 228	0	15, 139, 967	340, 567	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	9, 512	377, 229		843, 923	0	8. 00
9.00	00900 HOUSEKEEPI NG	4, 461	2, 758, 665		4, 228, 861	4, 270	9. 00
	01000 DI ETARY	16, 752	716, 448	1		16, 752	
	01100 CAFETERI A	2, 975	1, 300, 011	0	., ,	2, 975	
	01300 NURSI NG ADMI NI STRATI ON	8, 659	6, 050, 219	1	,	8, 659	
	01400 CENTRAL SERVI CES & SUPPLY	16, 171	1, 128, 346	1	3, 320, 003	15, 493	
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	8, 842 5, 428	2, 608, 764 652, 324	1		8, 842 5, 428	
	01700 SOCIAL SERVICE	0,428	1, 956, 843	1		0, 420	
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	1, 750, 045	· · · · · · · · · · · · · · · · · · ·	2,310,713	0	17.00
30. 00	03000 ADULTS & PEDIATRICS	75, 973	14, 152, 768	0	17, 013, 789	70, 160	30.00
	03100 INTENSIVE CARE UNIT	8, 811	3, 166, 151	l .		8, 811	31.00
43.00	04300 NURSERY	1, 668	1, 421, 929	0	1, 935, 375	1, 668	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						1
	05000 OPERATING ROOM	22, 461	2, 636, 611	0		22, 461	1
	05001 ENDOSCOPY	15, 546	1, 009, 253	l .		15, 546	1
	05100 RECOVERY ROOM	27, 411	1, 407, 294	l .	_, ,	27, 411	1
	05200 DELIVERY ROOM & LABOR ROOM	10, 983	2, 753, 106	l .		10, 983	1
	05300 ANESTHESI OLOGY	0	6, 793, 205	l .		0 20 957	53. 00 54. 00
	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI ATI ON-ONCOLOGY	37, 760 16, 778	6, 248, 190 1, 362, 223	l .		20, 857 0	54. 00
	05600 RADI OI SOTOPE	10, 778	1, 302, 223		17, 470, 203	0	56.00
	05601 NUCLEAR MEDICINE	527	205, 456	1	_	527	56. 01
	05900 CARDI AC CATHETERI ZATI ON	9, 533	575, 968	1		9, 533	
	06000 LABORATORY	12, 295	3, 390, 842	1		9, 022	1
64.00	06400 I NTRAVENOUS THERAPY	3, 327	1, 004, 964	0	1, 896, 280	3, 327	64. 00
65.00	06500 RESPI RATORY THERAPY	11, 459	2, 448, 331	0	3, 855, 722	10, 258	65. 00
66. 00	06600 PHYSI CAL THERAPY	24, 452	6, 065, 541	1	-, ,	10, 450	
	06700 OCCUPATI ONAL THERAPY	7, 191	525, 409	1		433	
68. 00	06800 SPEECH PATHOLOGY	2, 375	337, 414	1		2, 375	
	06900 ELECTROCARDI OLOGY	11, 030	889, 965	i		· ·	
	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	4, 900 2, 682	555, 681 123, 296	0		2, 956 2, 682	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,082	123, 240	i		2,002	
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		_	0	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	Ö		Ö	1
	07301 ULTRA SOUND	682	609, 876	0	801, 028	682	1
74.00	07400 RENAL DIALYSIS	0	263	0	329, 299	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	18, 000	1, 558, 331			0	
	09100 EMERGENCY	34, 707	6, 605, 009	0	9, 089, 681	22, 614	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
118. 00		622, 663	100, 005, 234	-56, 578, 575	182, 482, 464	326, 205	118 00
	NONREI MBURSABLE COST CENTERS	022,003	100,000,204	30, 370, 373	102, 404	320, 203	1
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	210, 828	47, 578, 123	0	77, 547, 562	1, 142	192. 00
	19201 HEALTH TRACKS	13, 335	3, 166, 732	l .	4, 768, 213		192. 01
194. 00	07950 PRIMARY CARE CLINIC	34, 673	917, 971		3, 435, 168	0	194. 00
	07951 PARTNERS IN CARE	0	0	16, 799			194. 01
	07952 OCCUPATI ONAL MEDI CI NE	4, 349	423, 235		1, 145, 284		194. 02
	07953 FOUNDATI ON	775	149, 690	1	218, 495		194. 03
	07954 SCHOOL & TOWN CLINICS	1, 148	1, 480, 190	1	_,,		194. 04
	07955 MANAGED FACILITY	0	448, 195	1	672, 731		194. 05
	07956 RENTAL PROPERTIES 07957 SNF NON CERTIFIED	13, 220	189 1, 326, 798	1	164, 267 2, 128, 552		194. 06 194. 07
200.00		13, 220	1,320,198	il .	2, 120, 332	13, 220	200. 00
200.00	Negative Cost Centers	1					201. 00
202.00		25, 675, 307	26, 275, 602		56, 578, 575	18, 253, 728	
203. 00	Unit cost multiplier (Wkst. B, Part I)	28. 496741	0. 168979		0. 205665	53. 598053	203. 00
204.00			316, 428	1	1, 792, 554	3, 418, 245	1

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od: From 01/01/2020	Worksheet B-1	
				To 12/31/2020	Date/Time Pre 7/30/2021 3:0	
	CAPI TAL					
	RELATED COSTS					
Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliatio	n ADMI NI STRATI VE	OPERATION OF	
	FLXT	BENEFITS		& GENERAL	PLANT	
	(SQUARE	DEPARTMENT		(ACCUM. COST)	(SQUARE	
	FEET)	(GROSS			FEET)	
		SALARI ES)			ĺ	
	1.00	4. 00	5A	5. 00	7. 00	
205.00 Unit cost multiplier (Wkst. B, Part		0. 002035		0. 006516	10. 036924	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D.						207. 00
Parts III and IV)						

Provider CCN: 15-0005

			To	12/31/2020	Date/Time Pre 7/30/2021 3:0	
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DIETARY	CAFETERI A	NURSI NG	<u>Б.</u>
	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(PATI ENT DAYS)	(MANHOURS)	ADMI NI STRATI ON	
	LAUNDRY)	Í	,		(DI RECT	
	8. 00	9. 00	10.00	11. 00	NRSING HRS) 13.00	
GENERAL SERVICE COST CENTERS	0.00	7.00	10.00		10.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 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	987, 136	1 505				8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	1, 595 10				9. 00 10. 00
11. 00 01100 CAFETERI A	0	17	0	1, 852, 917		11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	11	0	135, 820		13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	450 969	28	0	44, 354 59, 055	0 0	14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	2	o o	25, 329	0	16.00
17. 00 01700 SOCI AL SERVI CE	0	1	0	54, 542	0	17. 00
30.00 OSOOO ADULTS & PEDIATRICS	250, 637	282	17, 031	282, 802	282, 802	30.00
31. 00 03100 NTENSI VE CARE UNI T	68, 342	107		68, 719	68, 719	31.00
43. 00 04300 NURSERY	26, 327	4	2, 769	39, 065	39, 065	43. 00
44. 00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	51, 241	49	O	78, 263	78, 263	50.00
50. 01 05001 ENDOSCOPY	50, 437	38		26, 411	26, 411	50. 01
51. 00 05100 RECOVERY ROOM	44, 775	18		34, 224	34, 224	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	50, 973	50 2	0	75, 638 48, 570		52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	109, 176	108	١	161, 993		
54. 01 05401 RADI ATI ON-ONCOLOGY	6, 716	41	0	38, 028	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	56.00
56. 01 05601 NUCLEAR MEDICINE 59. 00 05900 CARDIAC CATHETERIZATION	0	0	0	5, 235 16, 201	5, 235 16, 201	56. 01 59. 00
60. 00 06000 LABORATORY	6, 967	73	-	122, 012	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	12	3	0	22, 178	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0 (5.030	5	0	69, 721	69, 721	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	65, 038 0	145 15		165, 728 13, 412	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	0	3	Ö	8, 608		68.00
69. 00 06900 ELECTROCARDI OLOGY	12, 527	16		37, 371	37, 371	69. 00
69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY	195	12 14	0	14, 562 3, 997	14, 562 0	69. 01 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 368	0		3, 997	0	70.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	Ö	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
73. 01 07301 ULTRA SOUND 74. 00 07400 RENAL DI ALYSI S	271	3	0	13, 997	0	73. 01 74. 00
OUTPATIENT SERVICE COST CENTERS	271	4	<u> </u>		0	74.00
90. 00 09000 CLI NI C	39, 646	110		0	0	90. 00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	141, 028	119	0	154, 497	154, 497	91. 00 92. 00
SPECIAL PURPOSE COST CENTERS						92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	927, 095	1, 299	22, 813	1, 820, 332	1, 113, 272	118. 00
NONREI MBURSABLE COST CENTERS	20, 701	210		0	0	100.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 HEALTH TRACKS	30, 791 6, 445	219 44		0		192. 00 192. 01
194.00 07950 PRIMARY CARE CLINIC	2, 785	9		0	0	194. 00
194. 01 07951 PARTNERS IN CARE	0	0	0	0		194. 01
194. 02 07952 OCCUPATI ONAL MEDI CI NE 194. 03 07953 FOUNDATI ON	882	21	0	0		194. 02 194. 03
194.04 07954 SCHOOL & TOWN CLINICS	307	2		0		194. 03
194.05 07955 MANAGED FACILITY	0	0	0	0		194. 05
194. 06 07956 RENTAL PROPERTIES	0	0	0	0		194. 06
194.07 07957 SNF NON CERTIFIED 200.00 Cross Foot Adjustments	18, 831	O	1, 970	32, 585	32, 585	200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	1, 017, 488	5, 327, 454	2, 557, 426	2, 198, 506	13, 518, 873	
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I	1. 030748	3 3/0 004553	103. 192753	1 104511	11 7000/5	303 00
204.00 Cost to be allocated (per Wkst. B,	277, 328	3, 340. 096552 203, 151		1. 186511 130, 162	11. 798045 426, 402	
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 280942	127. 367398	26. 511601	0. 070247	0. 372125	205. 00
)	ı		ı		I	I

Heal th Finar	ncial Systems	HENDRI CKS REG	ONAL HEALTH		In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co	CN: 15-0005	Peri od:	Worksheet B-1	
					From 01/01/2020 To 12/31/2020	Date/Time Pre	
						7/30/2021 3:0	6 pm
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE	(HOURS OF	(PATI ENT	(MANHOURS)	ADMI NI STRATI ON	
		(POUNDS OF	SERVI CE)	DAYS)			
		LAUNDRY)				(DI RECT	
						NRSING HRS)	
		8. 00	9. 00	10.00	11. 00	13.00	
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

17 00 01	600 MEDICAL RECORDS & LIBRARY	0	0	767, 314, 102		16.0
	700 SOCIAL SERVICE	0	0	0	21, 980	17. 0
I NF	PATIENT ROUTINE SERVICE COST CENTERS					
30. 00 030	000 ADULTS & PEDIATRICS	0	0	38, 370, 279	9, 183	30.0
31. 00 031	100 INTENSIVE CARE UNIT	0	0	14, 333, 594	1, 625	31. 0
43.00 043	BOO NURSERY	0	o	9, 453, 677	o	43. 0
14. 00 044	100 SKILLED NURSING FACILITY	0	o	0	ol	44. 0
	CILLARY SERVICE COST CENTERS		-1		-,	
	OOO OPERATING ROOM	100	0	72, 230, 058	8, 678	50. 0
	001 ENDOSCOPY	0	ő		0, 0, 0	50.0
		١	1	14, 139, 707	- 1	•
	100 RECOVERY ROOM	0	0	13, 763, 187	0	51. 0
1	200 DELIVERY ROOM & LABOR ROOM	0	0	18, 391, 209	0	52.0
1	BOO ANESTHESI OLOGY	0	0	20, 439, 777	O	53. 0
54. 00 054	100 RADI OLOGY-DI AGNOSTI C	0	0	78, 665, 412	0	54.0
54. 01 054	4O1 RADI ATI ON-ONCOLOGY	0	0	71, 394, 824	0	54. 0
56. 00 056	600 RADI OI SOTOPE	0	0	0	0	56.0
56. 01 056	NUCLEAR MEDICINE	0	ol	7, 411, 700	ol	56. (
	200 CARDI AC CATHETERI ZATI ON	0	0	26, 072, 281	o	59. (
	DOO LABORATORY	0	Ö	77, 685, 805	o	60.0
	100 INTRAVENOUS THERAPY	0	0	9, 870, 878	0	64.0
	i de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	0	ı "I			l
	500 RESPIRATORY THERAPY	0	0	20, 423, 636	0	65.
1	600 PHYSI CAL THERAPY	0	0	23, 599, 029	0	66.0
	700 OCCUPATI ONAL THERAPY	0	0	2, 583, 784	0	67. (
8. 00 068	BOO SPEECH PATHOLOGY	0	0	2, 390, 741	0	68. (
9.00 069	900 ELECTROCARDI OLOGY	0	0	19, 379, 905	0	69.
9. 01 069	PO1 CARDI AC REHAB	0	0	1, 860, 400	0	69. (
	000 ELECTROENCEPHALOGRAPHY	0	0	714, 892	o	70. (
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o	0	o	71. (
	200 IMPL. DEV. CHARGED TO PATIENT	0	o	22, 097, 451	0	72.
	BOO DRUGS CHARGED TO PATIENTS	0		50, 630, 020	0	
		_	100		-1	73. (
1	301 ULTRA SOUND	0	0	10, 558, 850	0	73. 0
	400 RENAL DIALYSIS	0	0	470, 263	0	74. 0
	TPATIENT SERVICE COST CENTERS					
	DOO CLINIC	0	0	35, 203, 496	0	90.0
4	100 EMERGENCY	0	0	105, 179, 247	2, 494	91. 0
92. 00 <u>09</u> 2	200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 0
SPE	CLIAL PURPOSE COST CENTERS					
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	100	100	767, 314, 102	21, 980	118. (
NON	NREIMBURSABLE COST CENTERS					
192. 00 192	200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192. (
192. 01 192	201 HEALTH TRACKS	0	o	0	ol	192. (
94.00 079	P50 PRIMARY CARE CLINIC	0	0	0	0	194.
	951 PARTNERS IN CARE	0	0	0	0	194. (
	952 OCCUPATIONAL MEDICINE	0	Ö	Ö	0	194.
		0	0	-	0	194.
94. 03107	953 FOUNDATION	0	0	0	-1	
1		0	0	0	0	194.
94. 04 079		_			OI.	194.
94. 04 079 94. 05 079	955 MANAGED FACILITY	0	0	0	9	
94. 04 079 94. 05 079		0	0	0 0	o	194.
94. 04 079 94. 05 079 94. 06 079	955 MANAGED FACILITY	0 0	0 0 0	_	0	
94. 04 079 94. 05 079 94. 06 079 94. 07 079	P55 MANAGED FACILITY P56 RENTAL PROPERTIES	0 0 0	0 0 0	_	0	194.
94. 04 079 94. 05 079 94. 06 079 94. 07 079	P55 MANAGED FACILITY P56 RENTAL PROPERTIES P57 SNF NON CERTIFIED Cross Foot Adjustments	0 0	0 0 0	_	0	194. 200.
94. 04 079 94. 05 079 94. 06 079 94. 07 079 00. 00 01. 00	P55 MANAGED FACILITY P56 RENTAL PROPERTIES P57 SNF NON CERTIFIED Cross Foot Adjustments Negative Cost Centers	0 0 0 4 979 820	0	0	0 0 0 3 095 136	194. 200. 201.
94. 04 079 94. 05 079 94. 06 079 94. 07 079 00. 00 01. 00	P55 MANAGED FACILITY P56 RENTAL PROPERTIES P57 SNF NON CERTIFIED Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0 0 0 4, 979, 820	0	_	3, 095, 136	194. 200. 201.
94. 04 079 94. 05 079 94. 06 079 94. 07 079 00. 00 01. 00 02. 00	PS5 MANAGED FACILITY PS6 RENTAL PROPERTIES PS7 SNF NON CERTIFIED Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)		0 5, 635, 277	2, 294, 029		194. 200. 201. 202.
94. 04 079 94. 05 079 94. 06 079 94. 07 079 200. 00 201. 00 202. 00	MANAGED FACILITY PS6 RENTAL PROPERTIES SNF NON CERTIFIED Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	49, 798. 200000	0 5, 635, 277 56, 352. 770000	2, 294, 029 0. 002990	140. 816015	194. 200. 201. 202.
194. 04 079 194. 05 079 194. 06 079 194. 07 079 200. 00 201. 00 202. 00	MANAGED FACILITY DE A RENTAL PROPERTIES SNF NON CERTIFIED Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,		0 5, 635, 277	2, 294, 029		194. (200. (201. (202. (
194. 04 079 194. 05 079 194. 06 079 194. 07 079 200. 00 201. 00 202. 00 203. 00 204. 00	MANAGED FACILITY PS6 RENTAL PROPERTIES PS7 SNF NON CERTIFIED Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	49, 798. 200000 647, 060	5, 635, 277 56, 352, 770000 378, 609	0 0 0 2, 294, 029 0. 002990 223, 148	140. 816015 24, 300	194. (200. (201. (202. (203. (204. (
194. 04 079 194. 05 079 194. 06 079	MANAGED FACILITY RENTAL PROPERTIES STATE OF SOME NON CERTIFIED Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II)	49, 798. 200000	0 5, 635, 277 56, 352. 770000	2, 294, 029 0. 002990	140. 816015	194. (194. (200. (201. (202. (203. (204. (205. (
194. 04 079 194. 05 079 194. 06 079 194. 07 079 200. 00 201. 00 202. 00 203. 00 204. 00	MANAGED FACILITY PS6 RENTAL PROPERTIES PS7 SNF NON CERTIFIED Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	49, 798. 200000 647, 060	5, 635, 277 56, 352, 770000 378, 609	0 0 0 2, 294, 029 0. 002990 223, 148	140. 816015 24, 300	194. (200. (201. (202. (203. (204. (
194. 04 079 194. 05 079 194. 06 079 194. 07 079 200. 00 201. 00 202. 00 203. 00 204. 00	MANAGED FACILITY RENTAL PROPERTIES STATE OF SOME NON CERTIFIED Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II)	49, 798. 200000 647, 060	5, 635, 277 56, 352, 770000 378, 609	0 0 0 2, 294, 029 0. 002990 223, 148	140. 816015 24, 300	194. 200. 201. 202. 203. 204.
94. 04 079 94. 05 079 94. 06 079 94. 07 079 200. 00 201. 00 202. 00 203. 00 204. 00	MANAGED FACILITY RENTAL PROPERTIES STATE OF SOME NON CERTIFIED Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II)	49, 798. 200000 647, 060	5, 635, 277 56, 352, 770000 378, 609	0 0 0 2, 294, 029 0. 002990 223, 148	140. 816015 24, 300	194. 200. 201. 202. 203. 204.
94. 04 079 94. 05 079 94. 06 079 94. 07 079 100. 00 101. 00 102. 00 103. 00 104. 00	MANAGED FACILITY RENTAL PROPERTIES STATE OF SOME NON CERTIFIED Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II)	49, 798. 200000 647, 060	5, 635, 277 56, 352, 770000 378, 609	0 0 0 2, 294, 029 0. 002990 223, 148	140. 816015 24, 300	194. 200. 201. 202. 203. 204.

Heal th Finar	ncial Systems	HENDRI CKS REG	ONAL HEALTH		In Lie	u of Form CMS	-2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B	-1
					From 01/01/2020 To 12/31/2020	Date/Time Pr	enared:
					10 12/31/2020	7/30/2021 3:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		SERVICES &	(100%	RECORDS &			
		SUPPLY	ALLOCATION)	LI BRARY	(TIME		
		(100%		(C)	SPENT)		
		ALLOCATION)					
		14. 00	15. 00	16.00	17. 00		
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Period: Worksheet C From 01/01/2020 Part I
		To 12/31/2020 Pate/Time Prepared

					To 12/31/2020	Date/Time Pre 7/30/2021 3:0	pared: 6 pm
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
	[1.00	2. 00	3. 00	4. 00	5. 00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	20 040 007		20.040.00	7 40 005	20 250 200	00.00
30.00	03000 ADULTS & PEDIATRICS	32, 310, 997		32, 310, 99		32, 359, 222	
31.00	03100 NTENSI VE CARE UNI T	7, 781, 799		7, 781, 79		7, 792, 289	
43.00	04300 NURSERY	3, 284, 562		3, 284, 56		3, 284, 562	1
44. 00	04400 SKILLED NURSING FACILITY	0			0 0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	14, 604, 657		14, 604, 65	7 0	14, 604, 657	50.00
50. 00	05000 PERATTING ROOM	3, 967, 658		3, 967, 65		3, 967, 658	
51. 00	05100 RECOVERY ROOM	5, 337, 569		5, 337, 56		5, 337, 569	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	6, 670, 100		6, 670, 10		6, 670, 100	1
53. 00	05300 ANESTHESI OLOGY	3, 274, 022		3, 274, 02		3, 274, 022	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	16, 309, 412		16, 309, 41		16, 309, 412	
54. 01	05401 RADI ATI ON-ONCOLOGY	21, 497, 115		21, 497, 11		21, 497, 115	
56. 00	05600 RADI OI SOTOPE	21, 477, 113		21, 477, 11	0	21, 477, 113	56.00
56. 01	05601 NUCLEAR MEDICINE	632, 895		632, 89	5 0	632, 895	56. 01
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 157, 481		3, 157, 48		3, 157, 481	59. 00
60. 00	06000 LABORATORY	13, 862, 998		13, 862, 99		13, 862, 998	
64. 00	06400 I NTRAVENOUS THERAPY	2, 530, 459		2, 530, 45		2, 530, 459	
65. 00	06500 RESPI RATORY THERAPY	6, 181, 581	0			6, 181, 581	
66. 00	06600 PHYSI CAL THERAPY	12, 175, 180	0			12, 175, 180	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 076, 774	0	1, 076, 77		1, 076, 774	
68. 00	06800 SPEECH PATHOLOGY	746, 275	0	746, 27		746, 275	1
69.00	06900 ELECTROCARDI OLOGY	2, 990, 193		2, 990, 19	3 0	2, 990, 193	69. 00
69. 01	06901 CARDI AC REHAB	1, 410, 011		1, 410, 01	1 0	1, 410, 011	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	487, 309		487, 30	9 0	487, 309	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	13, 387, 133		13, 387, 13	3 0	13, 387, 133	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	19, 744, 385		19, 744, 38		19, 744, 385	
73. 01	07301 ULTRA SOUND	1, 060, 524		1, 060, 52	4 0	1, 060, 524	73. 01
74.00	07400 RENAL DIALYSIS	412, 069		412, 06	9 0	412, 069	74. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	7, 287, 312		7, 287, 31		7, 287, 312	
91. 00	09100 EMERGENCY	15, 385, 525		15, 385, 52		15, 419, 526	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 471, 453		5, 471, 45		5, 471, 453	
200.00	,	223, 037, 448	0				
201.00		5, 471, 453	_	5, 471, 45		5, 471, 453	
202.00	Total (see instructions)	217, 565, 995	0	217, 565, 99	92, 716	217, 658, 711	J202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Peri od: Worksheet C
		From 01/01/2020 Part

				ļi	To 12/31/2020	Date/Time Pre 7/30/2021 3:0	pared: 6 pm
			Title	XVIII	Hospi tal	PPS	<u> </u>
			Charges	<u> </u>		<u>'</u>	
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'	· ·	'	+ col. 7)	Rati o	Inpati ent	
				,		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	33, 524, 154		33, 524, 154	1		30. 00
31.00	03100 INTENSIVE CARE UNIT	14, 333, 594		14, 333, 594	1		31.00
43.00	04300 NURSERY	9, 453, 677		9, 453, 677	7		43.00
44.00	04400 SKILLED NURSING FACILITY	O		(44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	18, 821, 418	53, 408, 640	72, 230, 058	0. 202196	0.000000	50.00
50. 01	05001 ENDOSCOPY	1, 011, 453	13, 128, 254	14, 139, 707	0. 280604	0.000000	50. 01
51.00	05100 RECOVERY ROOM	2, 693, 779	11, 069, 408	13, 763, 187	0. 387815	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	18, 039, 037	352, 172	18, 391, 209	0. 362679	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	5, 288, 403	15, 151, 374	20, 439, 777	0. 160179	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 560, 351	67, 105, 061	78, 665, 412	0. 207326	0.000000	54.00
54.01	05401 RADI ATI ON-ONCOLOGY	462, 834	70, 931, 990	71, 394, 824	0. 301102	0.000000	54. 01
56.00	05600 RADI OI SOTOPE	o	O	(0. 000000	0.000000	56.00
56. 01	05601 NUCLEAR MEDICINE	831, 188	6, 580, 512	7, 411, 700	0. 085391	0.000000	56. 01
59.00	05900 CARDI AC CATHETERI ZATI ON	11, 129, 331	14, 942, 950	26, 072, 281	0. 121105	0.000000	59. 00
60.00	06000 LABORATORY	19, 345, 331	58, 340, 474	77, 685, 805	0. 178450	0.000000	60.00
64.00	06400 I NTRAVENOUS THERAPY	87, 648	9, 783, 230	9, 870, 878	0. 256356	0.000000	64. 00
65.00	06500 RESPI RATORY THERAPY	11, 941, 408	8, 482, 228	20, 423, 636	0. 302668	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 910, 436	20, 283, 002	22, 193, 438	0. 548594	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 130, 377	1, 453, 407	2, 583, 784	0. 416743	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	584, 182	1, 806, 559	2, 390, 741	0. 312152	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	5, 184, 098	14, 195, 807	19, 379, 905	0. 154293	0.000000	69.00
69. 01	06901 CARDI AC REHAB	19, 692	1, 840, 708	1, 860, 400	0. 757907	0.000000	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	247, 023	467, 869	714, 892	0. 681654	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0	(0. 000000	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	10, 598, 747	11, 498, 704	22, 097, 451	0. 605822	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	18, 684, 130	31, 945, 890	50, 630, 020	0. 389974	0.000000	73. 00
73. 01	07301 ULTRA SOUND	1, 978, 901	8, 579, 949	10, 558, 850	0. 100439	0.000000	73. 01
74.00	07400 RENAL DIALYSIS	439, 422	30, 841	470, 263	0. 876252	0.000000	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	15, 803	35, 187, 693	35, 203, 496	0. 207005	0.000000	90. 00
91.00	09100 EMERGENCY	19, 028, 477	86, 150, 770	105, 179, 247	0. 146279	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 044, 213	2, 801, 912	4, 846, 125	1. 129037	0.000000	92. 00
200.00	Subtotal (see instructions)	220, 389, 107	545, 519, 404	765, 908, 511			200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	220, 389, 107	545, 519, 404	765, 908, 511			202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Peri od: Worksheet C Part I Date/Time Prepared: 7/30/2021 3:06 pm			

				10 12,01,2020	7/30/2021 3:00	6 pm
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
INF	PATIENT ROUTINE SERVICE COST CENTERS					
	000 ADULTS & PEDIATRICS					30. 00
	100 INTENSIVE CARE UNIT					31. 00
	300 NURSERY					43.00
	400 SKILLED NURSING FACILITY					44. 00
	CILLARY SERVICE COST CENTERS					
	OOO OPERATING ROOM	0. 202196				50.00
	001 ENDOSCOPY	0. 280604				50. 01
	100 RECOVERY ROOM	0. 387815				51. 00
52. 00 05:	200 DELIVERY ROOM & LABOR ROOM	0. 362679				52. 00
53. 00 053	300 ANESTHESI OLOGY	0. 160179				53. 00
54. 00 054	400 RADI OLOGY-DI AGNOSTI C	0. 207326				54. 00
54. 01 054	401 RADI ATI ON-ONCOLOGY	0. 301102				54. 01
56. 00 056	600 RADI OI SOTOPE	0. 000000				56. 00
56. 01 050	601 NUCLEAR MEDICINE	0. 085391				56. 01
	900 CARDI AC CATHETERI ZATI ON	0. 121105				59. 00
60.00 060	000 LABORATORY	0. 178450				60.00
	400 INTRAVENOUS THERAPY	0. 256356				64. 00
	500 RESPI RATORY THERAPY	0. 302668				65. 00
66. 00 066	600 PHYSI CAL THERAPY	0. 548594				66. 00
	700 OCCUPATI ONAL THERAPY	0. 416743				67. 00
68. 00 068	800 SPEECH PATHOLOGY	0. 312152				68. 00
1	900 ELECTROCARDI OLOGY	0. 154293				69. 00
69. 01 069	901 CARDI AC REHAB	0. 757907				69. 01
70. 00 070	000 ELECTROENCEPHALOGRAPHY	0. 681654				70. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. 00
	200 IMPL. DEV. CHARGED TO PATIENT	0. 605822				72. 00
	300 DRUGS CHARGED TO PATIENTS	0. 389974				73. 00
73. 01 07:	301 ULTRA SOUND	0. 100439				73. 01
74. 00 074	400 RENAL DIALYSIS	0. 876252				74. 00
	TPATIENT SERVICE COST CENTERS					
	OOO CLI NI C	0. 207005				90.00
	100 EMERGENCY	0. 146602				91. 00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 129037				92. 00
200. 00	Subtotal (see instructions)					200. 00
201.00	Less Observation Beds					201. 00
202.00	Total (see instructions)					202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Period: Worksheet C From 01/01/2020 Part I
		To 12/31/2020 Pate/Time Prepared

			T	o 12/31/2020	Date/Time Pre 7/30/2021 3:0	
		Ti tl	e XIX	Hospi tal	Cost	<u> </u>
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	32, 310, 997		32, 310, 997	48, 225	32, 359, 222	30. 00
31.00 03100 INTENSIVE CARE UNIT	7, 781, 799		7, 781, 799	10, 490	7, 792, 289	31.00
43. 00 04300 NURSERY	3, 284, 562		3, 284, 562	0	3, 284, 562	43.00
44.00 O4400 SKILLED NURSING FACILITY	0		0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	14, 604, 657		14, 604, 657	0	14, 604, 657	
50. 01 05001 ENDOSCOPY	3, 967, 658		3, 967, 658		3, 967, 658	
51.00 05100 RECOVERY ROOM	5, 337, 569		5, 337, 569	l .	5, 337, 569	
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 670, 100		6, 670, 100	0	6, 670, 100	
53. 00 05300 ANESTHESI OLOGY	3, 274, 022		3, 274, 022		3, 274, 022	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	16, 309, 412		16, 309, 412		16, 309, 412	
54. 01 05401 RADI ATI ON-ONCOLOGY	21, 497, 115	l e	21, 497, 115	0	21, 497, 115	
56. 00 05600 RADI 0I SOTOPE	0	l	0	<u>ا</u>	0	56. 00
56. 01 05601 NUCLEAR MEDICINE	632, 895		632, 895		632, 895	
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 157, 481		3, 157, 481	l .	3, 157, 481	
60. 00 06000 LABORATORY	13, 862, 998		13, 862, 998		13, 862, 998	
64. 00 06400 I NTRAVENOUS THERAPY	2, 530, 459	l	2, 530, 459		2, 530, 459	
65. 00 06500 RESPI RATORY THERAPY	6, 181, 581	0	6, 181, 581		6, 181, 581	
66. 00 06600 PHYSI CAL THERAPY	12, 175, 180		12, 175, 180		12, 175, 180	
67.00 06700 OCCUPATIONAL THERAPY	1, 076, 774		1, 076, 774		1, 076, 774	
68. 00 06800 SPEECH PATHOLOGY	746, 275		746, 275		746, 275	
69. 00 06900 ELECTROCARDI OLOGY	2, 990, 193		2, 990, 193	l .	2, 990, 193	
69. 01 06901 CARDI AC REHAB	1, 410, 011		1, 410, 011		1, 410, 011	
70. 00 07000 ELECTROENCEPHALOGRAPHY	487, 309		487, 309	0	487, 309	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	13, 387, 133		13, 387, 133		13, 387, 133	
73.00 07300 DRUGS CHARGED TO PATIENTS	19, 744, 385		19, 744, 385		19, 744, 385	
73. 01 07301 ULTRA SOUND	1, 060, 524		1, 060, 524		1, 060, 524	
74. 00 07400 RENAL DIALYSIS	412, 069		412, 069	0	412, 069	74. 00
OUTPATIENT SERVICE COST CENTERS	T	Г				
90. 00 09000 CLI NI C	7, 287, 312		7, 287, 312		7, 287, 312	
91. 00 09100 EMERGENCY	15, 385, 525		15, 385, 525		15, 419, 526	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	5, 471, 453		5, 471, 453		5, 471, 453	
200.00 Subtotal (see instructions)	223, 037, 448	i e	223, 037, 448	l	223, 130, 164	
201.00 Less Observation Beds	5, 471, 453		5, 471, 453		5, 471, 453	
202.00 Total (see instructions)	217, 565, 995	0	217, 565, 995	92, 716	217, 658, 711	J202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0005	Peri od: Worksh From 01/01/2020 Part I		

					To 12/31/2020	Date/Time Pre 7/30/2021 3:0	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	33, 524, 154		33, 524, 15	4		30. 00
31.00	03100 INTENSIVE CARE UNIT	14, 333, 594		14, 333, 59	4		31.00
43.00	04300 NURSERY	9, 453, 677		9, 453, 67	7		43.00
44.00	04400 SKILLED NURSING FACILITY	0			O		44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	18, 821, 418	53, 408, 640	72, 230, 05	0. 202196	0. 000000	50.00
50. 01	05001 ENDOSCOPY	1, 011, 453	13, 128, 254	14, 139, 70	7 0. 280604	0.000000	50. 01
51.00	05100 RECOVERY ROOM	2, 693, 779	11, 069, 408	13, 763, 18	7 0. 387815	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	18, 039, 037	352, 172	18, 391, 20	9 0. 362679	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	5, 288, 403	15, 151, 374	20, 439, 77	7 0. 160179	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 560, 351	67, 105, 061	78, 665, 41	0. 207326	0.000000	54.00
54. 01	05401 RADI ATI ON-ONCOLOGY	462, 834	70, 931, 990	71, 394, 82	4 0. 301102	0.000000	54. 01
56.00	05600 RADI OI SOTOPE	0	0		0.000000	0.000000	56.00
56. 01	05601 NUCLEAR MEDICINE	831, 188	6, 580, 512	7, 411, 70	0. 085391	0.000000	56. 01
59.00	05900 CARDI AC CATHETERI ZATI ON	11, 129, 331	14, 942, 950	26, 072, 28	0. 121105	0.000000	59. 00
60.00	06000 LABORATORY	19, 345, 331	58, 340, 474	77, 685, 80	0. 178450	0.000000	60.00
64.00	06400 I NTRAVENOUS THERAPY	87, 648	9, 783, 230	9, 870, 87	0. 256356	0.000000	64. 00
65.00	06500 RESPI RATORY THERAPY	11, 941, 408	8, 482, 228	20, 423, 63	6 0. 302668	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	1, 910, 436	20, 283, 002	22, 193, 43	0. 548594	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 130, 377	1, 453, 407	2, 583, 78	0. 416743	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	584, 182	1, 806, 559	2, 390, 74	0. 312152	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	5, 184, 098	14, 195, 807	19, 379, 90	0. 154293	0.000000	69. 00
69. 01	06901 CARDI AC REHAB	19, 692	1, 840, 708	1, 860, 40	0. 757907	0.000000	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	247, 023	467, 869	714, 89	0. 681654	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0.000000	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	10, 598, 747	11, 498, 704	22, 097, 45	0. 605822	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	18, 684, 130	31, 945, 890	50, 630, 02	0. 389974	0. 000000	73. 00
73. 01	07301 ULTRA SOUND	1, 978, 901	8, 579, 949	10, 558, 85	0. 100439	0. 000000	73. 01
74.00	07400 RENAL DI ALYSI S	439, 422	30, 841			0. 000000	74. 00
	OUTPATIENT SERVICE COST CENTERS		·				
90.00	09000 CLI NI C	15, 803	35, 187, 693	35, 203, 49	6 0. 207005	0.000000	90.00
91.00	09100 EMERGENCY	19, 028, 477	86, 150, 770			0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 044, 213	2, 801, 912	4, 846, 12	5 1. 129037	0.000000	92. 00
200.00		220, 389, 107	545, 519, 404				200. 00
201.00							201.00
202.00		220, 389, 107	545, 519, 404	765, 908, 51	1		202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Peri od: Worksheet C Part I Date/Time Prepared: 7/30/2021 3:06 pm			

				7/30/2021 3:06 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 O3100 I NTENSI VE CARE UNI T				31. 00
43. 00 04300 NURSERY				43.00
44. 00 O4400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS	0.000000			
50. 00 05000 OPERATING ROOM	0.000000			50.00
50. 01 05001 ENDOSCOPY	0. 000000			50. 01
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000			54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0. 000000			54. 01
56. 00 05600 RADI OI SOTOPE	0. 000000			56.00
56. 01 05601 NUCLEAR MEDICINE 59. 00 05900 CARDIAC CATHETERIZATION	0. 000000 0. 000000			56. 01 59. 00
	0. 000000			
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
69. 01 06901 CARDI AC REHAB	0. 000000			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
73. 01 07301 ULTRA SOUND	0. 000000			73. 01
74. 00 07400 RENAL DIALYSIS	0. 000000			74.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90. 00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH			In Lieu of Form CMS-2552-1		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider Co		Period: From 01/01/2020 To 12/31/2020		pared: 6 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 ADULTS & PEDI ATRI CS	3, 713, 115		3, 713, 11			
31. 00 INTENSIVE CARE UNIT	524, 258		524, 25	1		1
43. 00 NURSERY	181, 128		181, 12			
44.00 SKILLED NURSING FACILITY	0			0	0.00	
200.00 Total (lines 30 through 199)	4, 418, 501		4, 418, 50	1 25, 494		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS		4 400 500				
30. 00 ADULTS & PEDIATRICS	6, 044		1			30. 00
31. 00 INTENSIVE CARE UNIT	1, 072	186, 528				31. 00
43. 00 NURSERY	0	0				43. 00
44.00 SKILLED NURSING FACILITY	0	0				44. 00
200.00 Total (lines 30 through 199)	7, 116	1, 325, 036				200. 00

ealth Financial Systems	HENDRI CKS REG	IONAL HEALTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP			CN: 15-0005	Peri od: From 01/01/2020	Worksheet D	pared:
		Titl∈	e XVIII	Hospi tal	PPS	•
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)		Program	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4. 00	5. 00	

	Cost Center Description	Capi tal		Ratio of Cost	Inpatient	Capital Costs	
	0001 0011101 20001 1 p 1 1 0 1 1		(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col . 1 ÷ col .	Charges	column 4)	
		Part II, col.	8)	2)	onal goo	501 a 1)	
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	<u> </u>					
50.00	05000 OPERATING ROOM	1, 634, 879	72, 230, 058	0. 022634	7, 863, 667	177, 986	50. 00
50. 01	05001 ENDOSCOPY	649, 797	14, 139, 707	0. 045955	489, 499	22, 495	50. 01
51.00	05100 RECOVERY ROOM	1, 110, 835	13, 763, 187	0. 080711	813, 670	65, 672	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	514, 394	18, 391, 209	0. 027970	36, 813	1, 030	52. 00
53.00	05300 ANESTHESI OLOGY	55, 433	20, 439, 777	0. 002712	1, 719, 156	4, 662	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 503, 980	78, 665, 412	0. 019119	4, 679, 075	89, 459	54.00
54. 01	05401 RADI ATI ON-ONCOLOGY	625, 452	71, 394, 824	0. 008760	92, 388	809	54. 01
56.00	05600 RADI 0I SOTOPE	0	0	0.000000	0	0	56. 00
56. 01	05601 NUCLEAR MEDICINE	28, 307	7, 411, 700	0. 003819	417, 339	1, 594	56. 01
59.00	05900 CARDI AC CATHETERI ZATI ON	396, 012	26, 072, 281	0. 015189	4, 458, 652	67, 722	59. 00
60.00	06000 LABORATORY	559, 168	77, 685, 805	0. 007198	6, 470, 053	46, 571	60.00
64.00	06400 I NTRAVENOUS THERAPY	147, 418	9, 870, 878	0. 014935	43, 032	643	64. 00
65.00	06500 RESPI RATORY THERAPY	497, 032	20, 423, 636	0. 024336	4, 411, 870	107, 367	65. 00
66.00	06600 PHYSI CAL THERAPY	927, 630	22, 193, 438	0. 041797	932, 331	38, 969	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	219, 235	2, 583, 784	0. 084850	529, 143	44, 898	67. 00
68.00	06800 SPEECH PATHOLOGY	97, 085			252, 998	10, 274	68. 00
69.00	06900 ELECTROCARDI OLOGY	464, 237	19, 379, 905	0. 023955	2, 319, 086	55, 554	69. 00
69. 01	06901 CARDI AC REHAB	184, 494	1, 860, 400	0. 099169	4, 186	415	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	107, 813	714, 892	0. 150810	110, 266	16, 629	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	78, 423	22, 097, 451	0.003549	4, 039, 983	14, 338	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	468, 776	50, 630, 020	0.009259	6, 175, 630	57, 180	73. 00
73. 01	07301 ULTRA SOUND	37, 178	10, 558, 850	0. 003521	770, 102	2, 712	73. 01
74.00	07400 RENAL DIALYSIS	2, 869	470, 263	0. 006101	273, 118	1, 666	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	588, 113	35, 203, 496	0. 016706	1, 436	24	90. 00
91.00	09100 EMERGENCY	1, 445, 026	105, 179, 247	0. 013739	8, 253, 572	113, 396	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	627, 833	4, 846, 125	0. 129554	413, 462	53, 566	92.00
200.00	Total (lines 50 through 199)	12, 971, 419	708, 597, 086		55, 570, 527	995, 631	200.00

Health Financial Systems						
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider Co		Peri od:	Worksheet D	
				From 01/01/2020 To 12/31/2020		parad.
				10 12/31/2020	7/30/2021 3:0	pareu. 6 nm
		Title	· XVIII	Hospi tal	PPS	<u>o p</u>
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	00.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0		44. 00
200.00 Total (lines 30 through 199)	0	0		0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)					
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	19, 71:			1
31.00 03100 INTENSIVE CARE UNIT		0	3, 01:			
43. 00 04300 NURSERY		0	2, 76		l .	
44.00 04400 SKILLED NURSING FACILITY		0		0.00		1
200.00 Total (lines 30 through 199)		0	25, 49	4	7, 116	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
INDATI ENT DOUTINE CEDVI CE COCT CENTEDO	9. 00					

30. 00 31. 00

43. 00 44. 00 200. 00

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

Health Financial Systems	HENDRICKS REGIONA	AL HEALTH	H In Lieu		
APPORTIONMENT OF INPATIENT/OUTPATI	ENT ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0005	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared:	

				To 12/31/2020	Date/Time Pre 7/30/2021 3:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	(0	0	00.00
50. 01 05001 ENDOSCOPY	0	0	(0	0	50. 01
51.00 05100 RECOVERY ROOM	0	0	(0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	(0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0	0	(0	0	54. 01
56. 00 05600 RADI 01 SOTOPE	0	0	(0	0	56. 00
56. 01 05601 NUCLEAR MEDICINE	0	0	(0	0	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59. 00
60. 00 06000 LABORATORY	0	0	(0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0	0	(0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
69. 01 06901 CARDI AC REHAB	0	0	(0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
73.01 07301 ULTRA SOUND	0	0	(0	0	73. 01
74.00 07400 RENAL DIALYSIS	0	0	(0	0	74. 00
OUTPATIENT SERVICE COST CENTERS]
90. 00 09000 CLI NI C	0	0	(0	0	90. 00
91. 00 09100 EMERGENCY	0	0	(0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92. 00
200.00 Total (lines 50 through 199)	0	0		0	0	200. 00
· · · · · · · · · · · · · · · · · · ·		•		•		-

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 01/01/2020 To 12/31/2020		
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and	Total Outpatient Cost (sum of	(from Wkst. C, Part I, col.	Ratio of Cost to Charges (col. 5 ÷ col.	
	4 00	5.00	col s. 2, 3, and 4)	7 00	(see instructions)	

Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
				7.00	instructions)	
ANOLULA DIV. OF DIVI OF AGOT, OF NITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCI LLARY SERVI CE COST CENTERS	_		1	70 000 050		
50. 00 05000 OPERATING ROOM	0	0	0			50. 00
50. 01 05001 ENDOSCOPY	0	0	0	, ,		50. 01
51. 00 05100 RECOVERY ROOM	0	0	0	13, 763, 187		51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	18, 391, 209		52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	20, 439, 777		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	78, 665, 412		54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0	0	0	71, 394, 824		54. 01
56. 00 05600 RADI OI SOTOPE	0	0	0	0	0.000000	56.00
56. 01 05601 NUCLEAR MEDICINE	0	0	0	7, 411, 700	0. 000000	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	26, 072, 281	0. 000000	59.00
60. 00 06000 LABORATORY	0	0	0	77, 685, 805	0.000000	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	9, 870, 878	0. 000000	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0	0	20, 423, 636	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	22, 193, 438	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	2, 583, 784	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	2, 390, 741	0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	19, 379, 905	0. 000000	69. 00
69. 01 06901 CARDI AC REHAB	0	0	0	1, 860, 400	0. 000000	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	714, 892	0. 000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l o	l 0	0	0. 000000	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	22, 097, 451	0.000000	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0			
73. 01 07301 ULTRA SOUND	0	0	0			73. 01
74. 00 07400 RENAL DI ALYSI S	0	0	0			74. 00
OUTPATIENT SERVICE COST CENTERS	_	-	-			
90. 00 09000 CLI NI C	0	0	0	35, 203, 496	0.000000	90. 00
91. 00 09100 EMERGENCY	l o	l o	l o			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	l o	l o	l	4, 846, 125		92. 00
200.00 Total (lines 50 through 199)	0	Ö	Ö			200. 00

Heal th	Financial Systems	HENDRICKS REGIO	ΝΝΔΙ ΗΕΔΙΤΉ		In lie	eu of Form CMS-2	2552_10
APPOR1	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider Co		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 7/30/2021 3:06 pm	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	3	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS			Т		Г	
50.00	05000 OPERATING ROOM	0. 000000	7, 863, 667		0 10, 217, 450		50.00
50. 01	05001 ENDOSCOPY	0. 000000	489, 499		0 3, 070, 119	l	50. 01
51.00	05100 RECOVERY ROOM	0. 000000	813, 670		0 1, 955, 887	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	36, 813		0 0	0	52. 00 53. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0. 000000 0. 000000	1, 719, 156		0 3, 032, 521 0 13 434 362	0	54.00
54. 00	05401 RADI ATI ON-ONCOLOGY	0. 000000	4, 679, 075		.0, .0., 002	0	54.00
56. 00	05600 RADI OI SOTOPE	0. 000000	92, 388 0		0 8, 988, 397 0 0	0	56.00
56. 00	05601 NUCLEAR MEDICINE	0. 000000	417, 339		0 2, 098, 528		56. 01
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	4, 458, 652		0 2, 098, 328	l	59. 00
60.00	06000 LABORATORY	0. 000000	6, 470, 053		0 4, 473, 117	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	43, 032		0 4, 220, 892	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	4, 411, 870		0 2, 016, 185		65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	932, 331		0 2, 166, 444		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	529, 143		0 24, 605		67. 00
68. 00	06800 SPEECH PATHOLOGY	0.000000	252, 998		0 12, 273	l	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	2, 319, 086		0 3, 338, 473		69.00
69. 01	06901 CARDI AC REHAB	0. 000000	4, 186		0 642, 524	l e	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	110, 266		0 5, 321	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	110, 200 0		0,321	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	4, 039, 983		0 3, 347, 299	1	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	6, 175, 630		0 24, 547, 931	o o	73. 00
73. 01	07301 ULTRA SOUND	0. 000000	770, 102		0 1, 720, 707	o o	73. 01
74. 00	07400 RENAL DIALYSIS	0. 000000	273, 118		0 11, 027	Ō	74. 00

0. 000000

0. 000000

0.000000

1, 436 8, 253, 572

413, 462 55, 570, 527

7, 997, 198 14, 313, 012

1, 087, 250

115, 380, 426

0 0 0

0 90.00 0 91.00

0 92.00

0 200.00

91. 00 09100 EMERGENCY

200.00

OUTPATIENT SERVICE COST CENTERS

90. 00 O9000 CLINIC

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

Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0005 Worksheet D From 01/01/2020 Part V Date/Time Prepared: 12/31/2020 7/30/2021 3:06 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 202196 10, 217, 450 2, 065, 928 50.00 50.01 05001 ENDOSCOPY 0. 280604 3, 070, 119 0 0 861, 488 50.01 51. 00 05100 RECOVERY ROOM 0. 387815 0 0 1, 955, 887 51 00 758, 522 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0.362679 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0. 160179 3, 032, 521 485, 746 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.207326 13, 434, 362 0 0 2, 785, 293 54.00 05401 RADI ATI ON-ONCOLOGY 0 54.01 0.301102 8, 988, 397 2, 706, 424 54.01 56.00 05600 RADI OI SOTOPE 0.000000 0 0 56.00 56.01 05601 NUCLEAR MEDICINE 0.085391 2,098,528 0 0 179, 195 56.01 05900 CARDIAC CATHETERIZATION 4, 493, 119 544, 139 59 00 59 00 0 121105 0 60.00 06000 LABORATORY 0.178450 4, 220, 892 1,042 753, 218 60.00 06400 INTRAVENOUS THERAPY 0. 256356 2, 638, 902 0 0 676, 498 64.00 64.00 06500 RESPIRATORY THERAPY 0.302668 2, 016, 185 0 0 0 610, 235 65.00 0 65.00 1, 188, 498 06600 PHYSI CAL THERAPY 2, 166, 444 0 66.00 66.00 0.548594 67.00 06700 OCCUPATIONAL THERAPY 0.416743 24, 605 0 10, 254 67.00 06800 SPEECH PATHOLOGY 0. 312152 12, 273 68.00 3, 831 68.00 0 06900 ELECTROCARDI OLOGY 3, 338, 473 0 515, 103 69.00 0.154293 69.00 06901 CARDI AC REHAB 642, 524 0 69.01 0.757907 486, 973 69.01 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.681654 5, 321 3, 627 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 0 2, 027, 867 72.00 0.605822 3.347.299 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 389974 0 73.00 24, 547, 931 86, 563 9, 573, 055 73.00 07301 ULTRA SOUND 0.100439 1, 720, 707 0 172, 826 73.01 73.01 07400 RENAL DIALYSIS 9, 662 74.00 0.876252 11, 027 0 74.00 OUTPATIENT SERVICE COST CENTERS 7, 997, 198 90.00 09000 CLI NI C 0.207005 0 1, 655, 460 90.00 0. 146279 09100 EMERGENCY 14, 313, 012 0 2, 093, 693 91.00 546 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 129037 1,087,250 0 1, 227, 545 92.00 200.00 200.00 Subtotal (see instructions) 115, 380, 426 1,042 87, 109 31, 395, 080 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

115, 380, 426

1, 042

87, 109

31, 395, 080 202. 00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	HENDRI CKS REGI ONAL HEALTH				In Lie	u of Form CMS-2	2552-10	
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE	S AND	VACCI NE	COST	Provider C	CN: 15-0005	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prep 7/30/2021 3:00	pared: 6 pm
				Title	XVIII	Hospi tal	PPS	
			Costs	5				
Cost Center Description		Cos	t	Cost				

					7/30/2021 3:06	6 pm
		Title	XVIII	Hospi tal	PPS	
	Cos	sts		·		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	1			
ANCILLARY SERVICE COST CENTERS	'					
50. 00 05000 OPERATING ROOM	0	0				50.00
50. 01 05001 ENDOSCOPY	o	0				50. 01
51. 00 05100 RECOVERY ROOM	أم	0				51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	Ö	0				52. 00
53. 00 05300 ANESTHESI OLOGY		0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0				54. 00
54. 01 05401 RADI ATI ON-ONCOLOGY		0				54. 00
56. 00 05600 RADI OI SOTOPE	0	0				56. 00
	0	0				56. 00
56. 01 05601 NUCLEAR MEDICINE	U	0				
59. 00 05900 CARDI AC CATHETERI ZATI ON	100	0				59. 00
60. 00 06000 LABORATORY	186	0				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
69. 01 06901 CARDI AC REHAB	0	0				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	33, 757				73.00
73. 01 07301 ULTRA SOUND	0	0				73. 01
74.00 07400 RENAL DIALYSIS	o	0				74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90. 00
91. 00 09100 EMERGENCY	o	80				91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	0	1			92.00
200.00 Subtotal (see instructions)	186	33, 837			ļ	200. 00
201.00 Less PBP Clinic Lab. Services-Program	0	,				201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	186	33, 837			ļ	202. 00
1 11 111 1111 2111		22,007	1		ı	

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0005	Peri od: From 01/01/2020	Worksheet D-1		
		To 12/31/2020	Date/Time Pre 7/30/2021 3:0		
	Title XVIII	Hospi tal	PPS		
Cost Center Description					
			1. 00		
PART I - ALL PROVIDER COMPONENTS					

		Hospi tal	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)		19, 712	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19, 712	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private	e room days,	0	3. 00
	do not complete this line.			
4.00	Semi-private room days (excluding swing-bed and observation bed days)		16, 379	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31	of the cost	0	5. 00
	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of	6 414	0	/ 00
6. 00	reporting period (if calendar year, enter 0 on this line)	the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of	of the cost	0	7. 00
7.00	reporting period		Ü	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 swir	ng-bed and	6, 044	9. 00
40.00	newborn days) (see instructions)			40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room of through December 31 of the cost reporting period (see instructions)	lays)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room of	dave) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	adys) arter	O	11.00
12. 00		om days)	0	12.00
	through December 31 of the cost reporting period	,		
13.00		om 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	3 3 1		0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		U	16. 00
17. 00		2 cost	0.00	17. 00
17.00	reporting period	, 6631	0.00	17.00
18. 00		cost	0.00	18. 00
	reporting period			
19. 00		cost	0.00	19. 00
00.00	reporting period		0.00	00.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the correporting period)ST	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)		32, 359, 222	21. 00
22. 00	· · · · · · · · · · · · · · · · · · ·	period (line	0	22. 00
22.00	5 x line 17)	,	Ü	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting per	riod (line 6	0	23. 00
	x line 18)			
24. 00		eriod (line	0	24. 00
25 00	7 x line 19)	ad (line 0	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting peri	od (Trie 8	Ü	25. 00
26. 00			0	26. 00
27. 00	, , ,		32, 359, 222	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28. 00		5)	0	28. 00
29. 00			0	
30.00			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0. 000000	31.00
32. 00			0.00	32.00
33. 00 34. 00		-)	0. 00 0. 00	33.00
35. 00		١,	0.00	34. 00 35. 00
36. 00			0.00	36.00
37. 00	· · · · · · · · · · · · · · · · · · ·	ential (line	32, 359, 222	37. 00
200	27 minus line 36)		, 55 , 7 222	55
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38. 00		\neg	1, 641. 60	38. 00
39. 00			9, 921, 830	39. 00
40.00	, , , , , , , , , , , , , , , , , , , ,		0 001 000	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)		9, 921, 830	41.00

44.00 CORONARY CARE UNIT 45.00 BURN ITRESIVE CARE UNIT 45.00 BURN ITRESIVE CARE UNIT 45.00 CORONARY CARE UNIT 45.0	Heal th	Financial Systems	HENDRI CKS REGI	ONAL HEALTH		<u>In L</u> i e	eu of Form CMS-2	<u> 2552-</u> 10
Cost Centur Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C				
Total Tota							Date/Time Pre	
Total	-			Ti +l c	2 X//111	Hospi tal		6 pm
Col. 22		Cost Center Description	Total					
1.00 BURSERY (Little V & XIX only) 0 0 0 0 0 0 0 0 0		<u>'</u>	Inpatient Cost	Inpatient Days	Diem (col. 1		(col. 3 x col.	
MUSISIEY (TITLE V & XIX anly)			1.00	2.00		4.00		
Internsive Care Type Impatient Rospital Units	42. 00	NURSERY (title V & XIX onlv)						42. 00
44.00 CORONARY CARE UNIT 45.00 RBM ITRESIVE CARE UNIT 45		Intensive Care Type Inpatient Hospital Units						
45.00 SIRIO INTENSIVE CARE UNIT			7, 792, 289	3, 013	2, 586. 2	1, 072	2, 772, 428	
4.0 O O TOTAL PROPICAL CARE (DNIT 1.00								
1.00 Program Inpatient anciliary service cost (Wist. D.3. col. 3, line 200) 1.00								46. 00
1.00		OTHER SPECIAL CARE (SPECIFY)						47. 00
49.00 Program Inpatient and Illary service cost (Mist. D-3, col. 3, line 200) 14, 502, 625 48, 00 Program Inpatient costs (sum of Illane 3, lithrough 4B) (see Instructions) 27, 197, 083 27, 197, 083 37, 00 Pass through costs applicable to Program Inpatient routine services (from Wist. D, sum of Parts I and I) 325, 036 50, 00 Pass through costs applicable to Program Inpatient ancillary services (from Wist. D, sum of Parts II and II) 325, 036 50, 00 Pass through costs applicable to Program Inpatient ancillary services (from Wist. D, sum of Parts II and II) 325, 036 50, 00 Pass through costs applicable to Program Inpatient ancillary services (from Wist. D, sum of Parts II and II) 325, 00 Pass through costs applicable to Program Inpatient ancillary services (from Wist. D, sum of Parts II and II) 32, 00 Pass through costs applicable to Program Inpatient ancillary services (from Wist. D, sum of Parts III) 42, 320, 66 52, 00 24, 876, 416 53, 00 Pass through costs applicable to Program Inpatient ancillary services (from Wist. D, sum of Parts III) 42, 320, 66 52, 00 24, 876, 416 53, 00 Pass through costs applicable to Program Inpatient operating cost and 51) 95, 00		Cost Center Description					1.00	
40.00 Poss through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and D. 1,325,036 50.00 Poss through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and D. 1,325,036 50.00 Poss through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II 995,631 51.00 70.00 7	48 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)				48 00
PASS THROUGH COST ADJUSTMENTS					ons)			
111 51		PASS THROUGH COST ADJUSTMENTS						
51.00 Pass through costs applicable to Program Inpatient ancillary services (from Wkst. D, sum of Parts II and IV) 995,631 51.00 and IV) 2,320,667 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 2,320,667 52.00 75.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 2,320,667 52.00 75.00	50. 00		atient routine	services (from	n Wkst. D, sum	of Parts I and	1, 325, 036	50.00
	51. 00		atient ancillar	v services (fr	om Wkst. D. s	um of Parts II	995, 631	51. 00
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 7. ARGET AMOUNT AND LIMIT COMPUTATION 7. ARGET AMOUNT AND LIMIT COMPUTATION 7. OPPORTM discharge 7. OPPORTM dischar		and IV)		,	-, -,			
medical education costs (line 49 minus line 52) TARGET AMOUNT AND LINT COMPUTATION								
TARCET AMOUNT AND LIMIT COMPUTATION 54.00 FORT and Ischarges 0.54.00 55.00 Target amount (per discharge 0.00 55.00 55.00 Target amount (per discharge 0.00 55.00 55.00 55.00 55.00 55.00 55.00 56.	53. UU			rated, non-phy	ısıcıan anesth	erist, and	24, 8/6, 416	53.00
55.00 Target amount per discharge 0.00 55.00 55.00 57.00		TARGET AMOUNT AND LIMIT COMPUTATION	/					1
56.00 Target amount (line 54 x line 55) 0.56.00 56.00 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.57.00 58.00		, 3						
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 both payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 is less than the lower of lines 55,59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see Instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 69.00 Medically necessary private room cost applicable to Program (line 14 x line 25) 69.00 Medically necessary private room cost applicable to Program (line 14 x line 25) 69.00 Medically necessary private room cost applicable to Program (line 14 x line 25) 69.00 Medically necessary private room cost applicable to Program (line 14 x line 25) 69.00 Medically necessary private room cost applicable to Program (line 14 x line 25) 69.00 Medically necessary private room cost applicabl								
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from the cost report, updated by the market basket 61.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relicef payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (See instructions) 67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (See instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See instructions) 69.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 - line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 - line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 - line 68) 69.00 PARATIII - SKILLED NURSING FACILITY, Office RUISING FACILITY, Office North (See Cast (line 37)) 69.00 Program routine service cost (line 9 x line 71) 79.00 Program routine service cost (line 9 x line 71) 79.00 Program routine service cost (line 9 x line 71) 79.00 Program routine service cost (line 9 x line 71) 79.00 Agapter Drogram general inpatient routine service costs (from provider records) 80.00 Inpatient routine service cost (line 9 x line 71) 70.00 Program routine service cost (line 9 x line 71) 70.00 Program routine service cost (line 9 x line 71) 70.00 Program routine service cost (line 9 x line 78) 70.00 Prog			ing cost and ta	rget amount (I	ine 56 minus	line 53)		
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76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost per diem limitation 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost service (line 27 ÷ line 2)	75.00	'	ioutine service	COSIS (Trom V	vorksneet B, P	artii, COIUMN		/5.00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost (see instructions) 89.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	76. 00		ne 2)					76. 00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Reasonable inpatient routine service cost (see instructions) 79.00 Reasonable inpatient routine service see instructions) 79.00 Reasonable inpatient routine service costs (see instructions) 79.00 Reasonable inpatient routine service cost limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Utilization review - physician compensation (see instructions) 83.00 Reasonable inpatient oncillary services (see instructions) 84.00 Program inpatient operating costs (sum of lines 83 through 85) 70.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 70.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 84.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 85.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 86.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 87.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 79.00 Reasonable inpatient routine service costs limitation (line 78 minus line 79) 80.00 Reasonable inpatient routine 81.00 81.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 81.00 Reasonable inpatient routine service cost limitation (line 81) 82.00 Reasonable inpatient routine service cost limitation (line 81) 83.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 84.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 85.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 86.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 87.00 Reasonable inpatient routine service cost limitation 88.00 Reasonable inpatient routine service cost limitation 89.00 Reasonable inpatient routine service cost limitation 89.00 Reasonable inpatient routine service cost limitation 89.0		, ,	•					77. 00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Utilization review - physician compensation (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Total Program inpatient routine cost per diem (line 27 ÷ line 2)		1 .	,	rovider record	ls)			
82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 82.00 83.00 83.00 83.00 83.00						us line 79)		80.00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine		1 .		`				81.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 84.00 85.00 86.00 86.00 86.00 87.00 88.00		1 .		* .				
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		1		٥,				84.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,641.60 88.00	85. 00	Utilization review - physician compensation	(see instructio					85. 00
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 3,333 87.00 1,641.60 88.00	86. 00			rough 85)				86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,641.60 88.00	87 NN						3 333	87 00
89.00 Observation bed cost (line 87 x line 88) (see instructions) 5,471,453 89.00		1		line 2)			1, 641. 60	88. 00
	89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				5, 471, 453	89. 00

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020	Date/Time Prep 7/30/2021 3:00	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	3, 713, 115	32, 359, 222	0. 11474	7 5, 471, 453	627, 833	90.00
91.00 Nursing School cost	0	32, 359, 222	0.00000	0 5, 471, 453	0	91.00
92.00 Allied health cost	0	32, 359, 222	0.00000	0 5, 471, 453	0	92.00
93.00 All other Medical Education	0	32, 359, 222	0. 00000	5, 471, 453	0	93. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0005	Peri od: From 01/01/2020	Worksheet D-1	
		To 12/31/2020	Date/Time Pre 7/30/2021 3:0	
	Title XIX	Hospi tal	Cost	<u> </u>
Cost Center Description				
			1. 00	

		Title XIX	Hospi tal	7/30/2021 3:0 Cost	6 pm
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			19, 712	1. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day		vata room dave	19, 712 0	2. 00 3. 00
3.00	do not complete this line.	ys). If you have only pri	vate 100m days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		16, 379	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	om days) through Decembe	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December (R1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber .	or the cost		0.00
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	m days) after December 2	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) arter beceiiber 3	i or the cost	U	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	994	9. 00
10.00	newborn days) (see instructions)	-l (:ld:i			10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instructions)		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, er				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	Conly (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00 15. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14. 00 15. 00
16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			2, 769 0	16. 00
10.00	SWING BED ADJUSTMENT				10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	os after December 21 of	the cost	0.00	18. 00
16.00	reporting period	es arter becember 31 or	the cost	0.00	16.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 21 of th	an cost	0.00	20. 00
20.00	reporting period	s arter becember 51 or tr	ie cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			32, 310, 997	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporti	ng period (line	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
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)		(
26. 00	Total swing-bed cost (see instructions)	(1)		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		32, 310, 997	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3 ,	0	
30.00	Semi -private room charges (excluding swing-bed charges)	1: 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	÷ IIne 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mir		tions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 25)	ne 31)		0.00	35. 00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 32, 310, 997	36. 00 37. 00
57.00	27 minus line 36)			52, 510, 777	000
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 (20 15	38. 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 639. 15 1, 629, 315	
40. 00	Medically necessary private room cost applicable to the Progra	-		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 629, 315	41.00

	TAKT TT THOSE TALL AND SOURCE DERS ONE!		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 639. 15	38. (
39.00	Program general inpatient routine service cost (line 9 x line 38)	1, 629, 315	39. (
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. (
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 629, 315	41. (

	Financial Systems	HENDRI CKS REG			In Lie	eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 01/01/2020	Worksheet D-1	_
					To 12/31/2020		
			Ti tl	e XIX	Hospi tal	Cost	о рііі
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	3, 284, 562	2, 769	1, 186. 1	9 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	7, 781, 799	3, 013	2, 582. 7	4 0	0	43.00
44. 00	CORONARY CARE UNIT	7,701,777	3,013	2, 302. 7		Ĭ	44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
	1-					1.00	
48. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ne)		1, 135, 842 2, 765, 157	1
49.00	PASS THROUGH COST ADJUSTMENTS	41 thi ough 46)	see mstructro	115)		2, 705, 157	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	0	50.00
51. 00	<pre> </pre>	ationt ancillar	ry sorvices (fr	om Wkst D si	ım of Darte II	0	51.00
31.00	and IV)	atrent anciria	y services (II	OIII WKSt. D, SI	um of Farts II	0	31.00
52. 00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-phy	sician anesth	etist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
	Program di scharges					0	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
56. 00 57. 00	,	ing cost and ta	arget amount (ine 56 minus	ine 53)	0 0	
58. 00	Bonus payment (see instructions)	•			ŕ	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996, u	pdated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, up	odated by the m	arket basket		0.00	60.00
61.00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	er of 50% of		0	1
	which operating costs (line 53) are less tha		ts (lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	i iisti ucti olis)				0	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ıctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doss	mbor 21 of the	cost roporti	ag paried (Sac	Ιο	64. 00
04.00	instructions)(title XVIII only)	ts through bece	siliber 31 of the	cost reportir	ig period (see	0	04.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line 6	5)(title XVII	only) For	0	66. 00
00.00	CAH (see instructions)	110 00313 (11110	04 prus rrne o	5) (ti ti e XVIII	omy). To	l	00.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	n December 31 o	f the cost rep	porting period	0	67. 00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after [ecember 31 of	the cost repo	rting period	0	68. 00
00.00	(line 13 x line 20)		recember of or	the cost repo	tring perrou		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil		•				70.00
71. 00	Adjusted general inpatient routine service of	-					71.00
72.00	Program routine service cost (line 9 x line		. (14	25)			72.00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv			ne 35)			73.00
75. 00	Capital -related cost allocated to inpatient	•		orksheet B, Pa	art II, column		75. 00
74 00	26, line 45)	no 2)					76. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					77.00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for exces				is line 70)		79.00
80.00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		JOST TIMITATION	(TITIE /8 III N	us IIIIe /9)		80.00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	· * .				82. 00
83.00	Reasonable inpatient routine service costs (ns)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
	Total Program inpatient operating costs (sum						86.00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					0.000	07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	- line 2)			3, 333 1, 639. 15	•
	Observation bed cost (line 87 x line 88) (se	•	,			5, 463, 287	

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	3, 713, 115	32, 310, 997	0. 11491	5, 463, 287	627, 830	90.00
91.00 Nursing School cost	0	32, 310, 997	0.00000	5, 463, 287	0	91.00
92.00 Allied health cost	0	32, 310, 997	0.00000	5, 463, 287	0	92.00
93.00 All other Medical Education	0	32, 310, 997	0.00000	5, 463, 287	0	93. 00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi den Co	CN: 15-0005	Peri od:	Worksheet D-3	1
	11.001.401	10 0000	From 01/01/2020		
			To 12/31/2020	7/30/2021 3:0	
<u> </u>	Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs (col. 1 x col.	
			Charges	2)	
		1.00	2. 00	3. 00	-
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
0. 00 03000 ADULTS & PEDIATRICS			10, 014, 845		30.00
1.00 03100 INTENSIVE CARE UNIT			5, 634, 212		31.00
3. 00 04300 NURSERY					43. 0
ANCILLARY SERVICE COST CENTERS		1			4
0. 00 05000 OPERATI NG ROOM		0. 2021			
0. 01 05001 ENDOSCOPY 1. 00 05100 RECOVERY ROOM		0. 28060			
1.00 05100 RECOVERY ROOM 2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3878 ⁻ 0. 3626 ⁻	· ·		
3. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 3626		l	
4. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 1001			
4. 01 05401 RADI ATI ON-ONCOLOGY		0. 30110		1	1
6. 00 05600 RADI OI SOTOPE		0. 00000		l	1
6. 01 05601 NUCLEAR MEDICINE		0. 08539		35, 637	1
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 12110	05 4, 458, 652	539, 965	59.00
0. 00 06000 LABORATORY		0. 1784!		1, 154, 581	60.0
4. 00 06400 I NTRAVENOUS THERAPY		0. 2563			
5. 00 06500 RESPIRATORY THERAPY		0. 3026			
6. 00 06600 PHYSI CAL THERAPY		0. 54859		511, 471	1
.7. 00 06700 OCCUPATI ONAL THERAPY .8. 00 06800 SPEECH PATHOLOGY		0. 4167 0. 3121	· ·		
9. 00 06900 ELECTROCARDI OLOGY		0. 31213		1	1
9. 01 06901 CARDI AC REHAB		0. 75790		1	1
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 6816!			
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000	· ·		1
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 60582		2, 447, 511	1
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3899	74 6, 175, 630	2, 408, 335	73.0
3. 01 07301 ULTRA SOUND		0. 1004:	39 770, 102	77, 348	73.0
4.00 07400 RENAL DIALYSIS		0. 8762	52 273, 118	239, 320	74.0
OUTPATIENT SERVICE COST CENTERS					4
0. 00 09000 CLI NI C		0. 2070			
11. 00 09100 EMERGENCY		0. 14660			
12.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 1290:	· ·		
Total (sum of lines 50 through 94 and 96 through 98			55, 570, 527 0	1	1
01.00 Less PBP Clinic Laboratory Services-Program only ch	arges (TINE 61)	I	1 0	I	201. 0

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 01/01/2020	Worksheet D-3	
			To 12/31/2020		
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	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				1	4
0. 00 03000 ADULTS & PEDI ATRI CS			3, 035, 403		30.0
1.00 03100 INTENSIVE CARE UNIT			559, 208		31.0
3. 00 04300 NURSERY			353, 020		43.0
ANCILLARY SERVICE COST CENTERS					
0. 00 05000 OPERATI NG ROOM		0. 20219			
0. 01 05001 ENDOSCOPY		0. 28060			50.0
1. 00 05100 RECOVERY ROOM		0. 38781			
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 36267			52.0
3. 00 05300 ANESTHESI OLOGY		0. 16017			53.0
4. 00 05400 RADI OLOGY - DI AGNOSTI C 4. 01 05401 RADI ATI ON - ONCOLOGY		0. 20732			
4. 01 05401 RADI ATI ON-ONCOLOGY 6. 00 05600 RADI OI SOTOPE		0. 30110		160	56.
6. 01 05600 RADI OFSOTOPE 6. 01 05601 NUCLEAR MEDI CI NE		0.00000		0	56.
		0. 08539 0. 12110		2, 524 18, 403	
9. 00 05900 CARDI AC CATHETERI ZATI ON 0. 00 06000 LABORATORY		0. 12110			
4. 00 06400 INTRAVENOUS THERAPY		0. 17643	· ·	137,002	64.
5. 00 06500 RESPI RATORY THERAPY		0. 30266		125, 699	65.
6. 00 06600 PHYSI CAL THERAPY		0. 54859			
7. 00 06700 OCCUPATI ONAL THERAPY		0. 41674			
8. 00 06800 SPEECH PATHOLOGY		0. 31215			1
9. 00 06900 ELECTROCARDI OLOGY		0. 15429		23, 825	
9. 01 06901 CARDI AC REHAB		0. 75790			69. (
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 68165			
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		7,000	71. (
2.00 07200 MPL. DEV. CHARGED TO PATIENT		0. 60582			
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 38997			
3. 01 07301 ULTRA SOUND		0. 10043	· ·		73.
4. 00 07400 RENAL DIALYSIS		0. 87625			1
OUTPATIENT SERVICE COST CENTERS			, , , , , , , , , , , , , , , , , , , ,		

0. 207005 0. 146279

1. 129037

616, 732

4, 210, 966

4, 210, 966

90.00

91.00

0 92.00

201. 00 202. 00

90, 215

1, 135, 842 200. 00

90.00

202.00

09000 CLINIC

92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

91. 00 09100 EMERGENCY

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTL	.EMENT Provider CCN: 15-0005	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/30/2021 3:06 pm

			10 12/31/2020	7/30/2021 3:0	
		Title XVIII	Hospi tal	PPS	
	DADT A LABATIENT HOODITAL CERVICES UNDER LDDS			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1. 00
1. 00 1. 01	DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (s	see	12, 659, 797	1. 00
1. 02	instructions) DRG amounts other than outlier payments for discharges occurri	ng on or after October	l (see	5, 339, 643	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI fo	r discharges occurring i	orior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI fo			0	1. 04
	October 1 (see instructions)	r di sendi ges occurring (on or arter	Ü	
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 01
2. 03	Outlier payments for discharges occurring prior to October 1 (,		792, 380	2. 02
2. 04	Outlier payments for discharges occurring on or after October			235, 530	2. 04
3.00	Managed Care Simulated Payments	. (55551. 451.55)		0	3.00
4.00	Bed days available divided by number of days in the cost repor	ting period (see instru	ctions)	120. 56	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most			0. 00	5. 00
	or before 12/31/1996. (see instructions)		ŭ		
6. 00	FTE count for allopathic and osteopathic programs that meet th new programs in accordance with 42 CFR 413.79(e)			0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified u ACA \S 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopat	hic and osteonathic pro	arams for	0. 00	8. 00
0.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.7			0.00	0.00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slo	ts under § 5503 of the A	ACA. If the cost	0. 00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slo	ts from a closed teachi	ng hospital	0. 00	8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	s (8, 8,01 and 8,02) (see	0.00	9. 00
10. 00	<pre>instructions) FTE count for allopathic and osteopathic programs in the curre</pre>	nt year from your record	ds	0. 00	10. 00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11. 00
12.00	Current year allowable FTE (see instructions)			0.00	
13.00	Total allowable FTE count for the prior year.			0. 00	
14. 00	Total allowable FTE count for the penultimate year if that yea	r ended on or after Sep [.]	tember 30, 1997,	0. 00	14. 00
15 00	otherwise enter zero.			0.00	15 00
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0.00	15. 00 16. 00
	Adjustment for residents displaced by program or hospital clos	ure			17. 00
	Adjusted rolling average FTE count	a. 6		0. 00	
	Current year resident to bed ratio (line 18 divided by line 4)			0.000000	
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21. 00
	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	C II MAA		0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 Number of additional allopathic and osteopathic IME FTE reside		FR 412. 105	0. 00	23. 00
24.00	(f)(1)(iv)(C).			0.00	24.00
24. 00	IME FTE Resident Count Over Cap (see instructions)	awar of line 22 or line	24 (000	0.00	
25. 00	If the amount on line 24 is greater than -0-, then enter the linstructions)	ower of line 23 of 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	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)	_		0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01 Disproportionate Share Adjustment)		0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	tient days (see instruc	tions)	1. 04	30.00
31. 00	Percentage of Medicaid patient days (see instructions)			18. 65	
32. 00	Sum of lines 30 and 31			19. 69	
	Allowable disproportionate share percentage (see instructions)				33. 00
34. 00	Disproportionate share adjustment (see instructions)			249, 743	34. 00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0005	Peri od: From 01/01/2020	Worksheet E Part A	
			To 12/31/2020	Date/Time Pre 7/30/2021 3:0	pare
		Title XVIII	Hospi tal	PPS	о ріі
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment		1.00	2.00	
. 00	Total uncompensated care amount (see instructions)		8, 350, 599, 096		1
. 01 . 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, ent	or zoro on this line) (se	0. 000205375 e 1, 715, 008	0. 000288232 2, 389, 448	1
. 02	instructions)	er zero on tilis i ne) (se	1, 715, 006	2, 309, 440	33
03	Pro rata share of the hospital uncompensated care payment am		1, 283, 913		
00	Total uncompensated care (sum of columns 1 and 2 on line 35. Additional payment for high percentage of ESRD beneficiary d		1, 886, 185		36
00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683,		0		40
	instructions)				١
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0		41
. 01	1	S-DRGs 652, 682, 683, 684	0		41
00	an 685. (see instructions)	: 6 . 6	0.00		4.0
00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6	,	0.00		42
	instructions)	,, ('
00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44
00	days) Average weekly cost for dialysis treatments (see instruction	ns)	0.00		45
00	Total additional payment (line 45 times line 44 times line 4	•	0		46
00	Subtotal (see instructions)	small rural bassitals	21, 163, 278		47
00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	silari rurai nospitars	0		40
				Amount	
00	Total payment for inpatient operating costs (see instruction	nc)		1. 00 21, 163, 278	49
00	Payment for inpatient program capital (from Wkst. L, Pt. I a	•		1, 554, 270	
00	Exception payment for inpatient program capital (Wkst. L, Pt	. III, see instructions)		0	5
00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment	ine 49 see instructions).		0	52
00	Special add-on payments for new technologies			26, 546	
01	Islet isolation add-on payment			0	5
00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	•		0	
00	Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt.		hrough 35).	0	5
00	Ancillary service other pass through costs from Wkst. D, Pt.			0	5
00	Total (sum of amounts on lines 49 through 58)			22, 744, 094	
00	Primary payer payments Total amount payable for program beneficiaries (line 59 minu	us line 60)		24, 051 22, 720, 043	
00	Deductibles billed to program beneficiaries			1, 980, 044	
00	Coinsurance billed to program beneficiaries			16, 192	
00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			66, 930 43, 505	1
00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		24, 395	1
00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			20, 767, 312	
00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)		,	0	1
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. (101 301 see This ti de troil	5)	0	1
50	Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see	instructions)	0	
87	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	1		0	
88 89	Pioneer ACO demonstration payment adjustment amount (see ins	structions)		0	70
90	HSP bonus payment HVBP adjustment amount (see instructions)			0	1
91	HSP bonus payment HRR adjustment amount (see instructions)			0	
92 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 56, 861	70
. 93 . 94	HRR adjustment amount (see instructions)			-17, 339	
	Recovery of accelerated depreciation			0	70

Heal th	Financial Systems HENDRICKS REGION	IAL HEALTH		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0005	Peri od: From 01/01/2020 To 12/31/2020		pared: 6 pm
		Titl∈	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			0	0	70. 97
70. 98	Low Volume Payment-3				0	70. 9
70. 99	HAC adjustment amount (see instructions)				0	70. 9
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			20, 806, 834	71.00
71. 01	Sequestration adjustment (see instructions)				137, 325	71. 0°
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71.03
72. 00	Interim payments				20, 392, 540	72.00
72. 01	Interim payments-PARHM					72. 0°
73. 00	Tentative settlement (for contractor use only)				0	
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 0
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0	2, 72, and			276, 969	74.00

74. 01

75.00

90.00

91.00

92.00

94.00

95.00

0

0

0 93.00

0

0 96.00

0.00

352, 859

	Prior to 10/1	On/After 10/1	
	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0.000000000	0.0000000000	101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	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 currer	nt 5-year demonst	rati on	
peri od)			
204.00 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)			213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218. 00
(line 212 minus line 213) (see instructions)			

74. 01

75.00

90.00

91.00

92.00

93.00

94.00

95.00

Balance due provider/program-PARHM (see instructions)

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

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)

Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)

Capital outlier from Wkst. L Pt. L line 2

Operating outlier reconciliation adjustment amount (see instructions)

The rate used to calculate the time value of money (see instructions)

Capital outlier reconciliation adjustment amount (see instructions)

Time value of money for operating expenses (see instructions)

96.00 Time value of money for capital related expenses (see instructions)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2020 | Part A Exhibit 4 | To 12/31/2020 | Date/Time Prepared: | 7/30/2021 3:06 pm Provider CCN: 15-0005

					'	127 317 2020	7/30/2021 3:0	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1.00	DRG amounts other than outlier		1.00	2.00	3.00		0.00	1.00
	payments		١	ŭ	Ì			
1. 01	DRG amounts other than outlier payments for discharges	1. 01	12, 659, 797	0	12, 659, 797	,	12, 659, 797	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	5, 339, 643	0		5, 339, 643	5, 339, 643	1. 02
	occurring on or after October							
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	(0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	(0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	792, 380	0	792, 380		792, 380	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	235, 530	O		235, 530	235, 530	2. 03
3. 00	Operating outlier reconciliation	2. 01	0	0	(0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	(0	0	4. 00
	Indirect Medical Education Adj	ustment						
5. 00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	(0	0	6. 00
6. 01	instructions) IME payment adjustment for managed care (see	22. 01	0	0	(0	0	6. 01
	instructions)							ļ
7.00	Indirect Medical Education Adju					0.00000		7 00
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	8. 00
8. 01	IME payment adjustment add on for managed care (see	28. 01	O	0	(0	0	8. 01
9. 00	instructions) Total IME payment (sum of lines 6 and 8)	29. 00	0	0	(0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	(0	0	9. 01
	8. 01)	L						
10. 00	Disproportionate Share Adjustment Allowable disproportionate	ent 33.00	0. 0555	0. 0555	0. 0555	0. 0555		10.00
10.00	share percentage (see instructions)	33.00	0.0555	0. 0555	0.055	0.0555		10.00
11. 00	Disproportionate share adjustment (see instructions)	34.00	249, 743	0	175, 655	74, 088	249, 743	11. 00
11. 01	Uncompensated care payments Additional payment for high per	36.00 rcentage of ESF	1,886,185 RD beneficiary (0 di scharges	1, 283, 913	602, 272	1, 886, 185	11. 01
12. 00	Total ESRD additional payment	46.00	o	0	(0	0	12. 00
4 =	(see instructions)							
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	21, 163, 278 0	0	14, 911, 745 (6, 251, 533 0	21, 163, 278 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49.00	21, 163, 278	O	14, 911, 745	6, 251, 533	21, 163, 278	15. 00
16. 00	<pre>instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)</pre>	50.00	1, 554, 270	O	1, 110, 891	443, 379	1, 554, 270	16. 00
						·		

					-	From 01/01/2020 To 12/31/2020	Part A Exhibit Date/Time Pre 7/30/2021 3:0	pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3. 00	4. 00	5. 00	
17.00	Special add-on payments for	54.00	26, 546	0	(26, 546	26, 546	17. 00
	new technologies							
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from	68. 00	0	0	(0	0	17. 02
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18. 00	Capital outlier reconciliation	93. 00	0	0	(0	0	18. 00
	adjustment amount (see							
	instructions)							
19. 00	SUBTOTAL			0	16, 022, 63	6, 721, 458	22, 744, 094	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	1, 392, 993	0	999, 54	1 393, 452	1, 392, 993	20. 00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	(0	0	20. 01
	than outlier							
21. 00	Capital DRG outlier payments	2. 00	104, 582	0	70, 668	33, 914	104, 582	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	(0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0000	0. 0000	0. 0000	0.0000		22. 00
	percentage (see instructions)							
23. 00	Indirect medical education	6. 00	0	0	(0	0	23. 00
	adjustment (see instructions)							
24. 00	Allowable disproportionate	10. 00	0. 0407	0. 0407	0. 040	0. 0407		24. 00
	share percentage (see							
	instructions)			_				
25. 00	Di sproporti onate share	11. 00	56, 695	0	40, 682	16, 013	56, 695	25. 00
	adjustment (see instructions)	40.00	4 554 070		4 440 00		4 554 656	
26. 00	Total prospective capital	12. 00	1, 554, 270	0	1, 110, 89°	1 443, 379	1, 554, 270	26.00
	payments (see instructions)	W/S E, Part A	(Amounto to F					
		line						
		0	Part A) 1.00	2.00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor	U	1.00	2.00	0. 00000		5.00	27. 00
28. 00	Low volume adjustment ractor	70. 96			0.000000	0.000000	0	
26.00	(transfer amount to Wkst. E,	70.90			(J	U	20.00
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				0	0	29. 00
29.00	(transfer amount to Wkst. E,	70. 77				U	U	29.00
	Pt. A, line)							
100 00	Transfer low volume		Υ					100.00
100.00	adjustments to Wkst. E, Pt. A.		'					130.00
	judy dot more to more E, Tt. A.	I	1		ı	1	l	I

HUSPII	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	IION EXHIBIT 5		F	From 01/01/2020 o 12/31/2020	Date/Time Prep 7/30/2021 3:00	pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2. 00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	12, 659, 797	12, 659, 797	,	12, 659, 797	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	5, 339, 643		5, 339, 643	5, 339, 643	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	(0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2.00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	(
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	792, 380			792, 380	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	235, 530		235, 530		
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0	(
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0.000000		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	0		0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	(
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8. 00	instructions) IME adjustment (see instructions)	28. 00	0		0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0				
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	0	(0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	(0	0	9. 01
	Di sproporti onate Share Adjustment						
10. 00	Allowable disproportionate share percentage	33. 00	0. 0555	0. 0555	0. 0555		10.00
11. 00	(see instructions) Disproportionate share adjustment (see instructions)	34.00	249, 743	175, 655	74, 088	249, 743	11. 00
11. 01	Uncompensated care payments	36.00	1, 886, 185	1, 283, 913	602, 272	1, 886, 185	11. 01
40	Additional payment for high percentage of ESF		di scharges				
12.00	Total ESRD additional payment (see instructions)	46.00	0	(
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47. 00 48. 00	21, 163, 278	14, 911, 745 (6, 251, 533 0	21, 163, 278	1
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	21, 163, 278	14, 911, 745	6, 251, 533	21, 163, 278	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	1, 554, 270	1, 110, 891	443, 379	1, 554, 270	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	26, 546	(26, 546	26, 546	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	(0	0	1
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0				
19. 00	SUBTOTAL		1	16, 022, 636	6, 721, 458	22, 744, 094	19.00

Heal th	Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 01/01/2020 To 12/31/2020		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	1, 392, 993	999, 54	1 393, 452	1, 392, 993	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	104, 582	70, 66	8 33, 914	104, 582	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0407	0. 040	7 0.0407		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	56, 695	40, 68	2 16, 013	56, 695	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 554, 270	1, 110, 89	1 443, 379	1, 554, 270	26. 00
		Wkst. E, Pt.	(Amt. from				
		A 1:00	Wko+ F D+				

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	From 01/01/2020	Worksheet E Part B Date/Time Prepared: 7/30/2021 3:06 pm

		Title XVIII	Hospi tal	7/30/2021 3: 0 PPS	6 pm
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			34, 023	
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	i ons)		31, 395, 080 21, 063, 490	
4.00	Outlier payment (see instructions)			21, 003, 490	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	1
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0. 000	
6.00	Line 2 times line 5			0	
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	ı
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V. col. 13. line 200		0	1
10.00	Organ acqui si ti ons	.,,		0	ı
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			34, 023	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
12. 00	Reasonable charges Ancillary service charges			88, 151	12 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		00, 131	1
14.00	Total reasonable charges (sum of lines 12 and 13)	<u> </u>		88, 151	14. 00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for p	3	•	0	
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e	. 3	i a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			88, 151	18. 00
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	54, 128	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete onl</pre>	y if line 11 exceeds li	ne 18) (see	0	20.00
21 00	instructions)		, ,	34, 023	21. 00
	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			34, 023	1
	Cost of physicians' services in a teaching hospital (see instr	ructions)		Ö	1
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			21, 279, 791	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions Deductibles and Coinsurance amounts relating to amount on line	•	ictions)	0 3, 909, 296	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			17, 404, 518	
27.00	instructions)	45 1.15 54 61 1.1165 22	a.ia 20] (000	.,,,	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29) Primary payer payments			17, 404, 518 2, 300	
	Subtotal (line 30 minus line 31)			17, 402, 218	ı
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			273, 305 177, 648	1
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		159, 207	
	Subtotal (see instructions)	,		17, 579, 866	
	MSP-LCC reconciliation amount from PS&R			3	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration	5)		0	39. 50 39. 97
39. 98	Partial or full credits received from manufacturers for replac	ed devices (see instruc	tions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	(000 000 000	,	0	1
40.00	Subtotal (see instructions)			17, 579, 863	40. 00
40. 01	Sequestration adjustment (see instructions)			116, 027	
40. 02	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40. 02 40. 03
	Interim payments			17, 473, 509	
41. 01	Interim payments-PARHM			,,	41. 01
	Tentative settlement (for contractors use only)			0	1
42. 01	Tentative settlement-PARHM (for contractor use only)			0 (70	42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-9,6/3	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordan	ice with CMS Pub. 15-2,	chapter 1,	0	1
	§115. 2				-
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00	The rate used to calculate the Time Value of Money			0.00	92. 00
93. 00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems HEND ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0005

			''	0 12/31/2020	7/30/2021 3:06	
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		20, 315, 484		17, 280, 718	1. 00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2. 00
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. 00
3.01	ADJUSTMENTS TO PROVIDER	12/31/2020	77, 056	12/31/2020	141, 091	3. 01
3.02			0	08/26/2020	51, 700	3. 02
3.03			0		o	3. 03
3.04			0		o	3.04
3.05			0		o	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		77, 056		192, 791	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		20, 392, 540		17, 473, 509	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			l		
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		o	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5.51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		276, 969		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		9, 673	6. 02
7.00	Total Medicare program liability (see instructions)		20, 669, 509		17, 463, 836	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
		1		'	'	

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared:

			To 12/31/2020	Date/Time Pre 7/30/2021 3:0	
		Title XIX	Hospi tal	Cost	о рііі
		THE XIX	Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	/ICES FOR TITLES V OR XI			
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		2, 765, 157		1.00
2.00	Medical and other services		,	0	
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		2, 765, 157	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2, 765, 157	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		3, 947, 631		8. 00
9.00	Ancillary service charges		4, 210, 966	0	
10. 00	Organ acquisition charges, net of revenue		0		10. 00
	i i		0	_	11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		8, 158, 597	0	12. 00
40.00	CUSTOMARY CHARGES	 			
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14.00	basis			0	14 00
14. 00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42		0	0	14. 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 CFR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		8, 158, 597	0.000000	
17. 00	Excess of customary charges over reasonable cost (complete only	/if line 16 exceeds	5, 393, 440	0	
17.00	line 4) (see instructions)	, it tille to execeus	0,070,110	Ü	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	vifline 4 exceeds line	0	0	18. 00
	16) (see instructions)	,			
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16	5)	2, 765, 157	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be of	completed for PPS provide	ers.		
	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	20.00
24. 00	Program capital payments		0		24. 00
25. 00	1		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0 7/5 457	0	
29. 00			2, 765, 157	0	29. 00
30. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	30.00
30.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		-	0	
32. 00	Deductibles		2, 765, 157	0	
33. 00			0	0	1
34. 00			0	0	
35. 00	Utilization review		0	O	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	2, 765, 157	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	55)	2, 700, 107	0	
	Subtotal (line 36 ± line 37)		2, 765, 157	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	ŭ	39. 00
40. 00	,		2, 765, 157	0	
41. 00	Interim payments		3, 351, 991	0	
42. 00	Balance due provider/program (line 40 minus line 41)		-586, 834	0	
43.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2,	0	0	1
	chapter 1, §115.2				

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

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

Provider CCN: 15-0005

Peri od: Worksheet G From 01/01/2020 To 12/31/2020 Date/Time Prepared:

7/30/2021 3:06 pm Speci fi c Endowment Fund General Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 1.00 1.00 Cash on hand in banks 40, 691, 776 0 0 0 0 0 2.00 Temporary investments 0 2.00 0 3.00 Notes receivable 0 0 3.00 0 4 00 26, 931, 930 4 00 Accounts receivable 0 0 5.00 Other receivable 0 0 5.00 6.00 Allowances for uncollectible notes and accounts receivable 6.00 0 7.00 Inventory 3.077.676 0 0 7.00 0 8.00 Prepaid expenses 0 8.00 0 9.00 Other current assets 39, 819, 472 0 9.00 10 00 Due from other funds 0 0 0 10 00 Total current assets (sum of lines 1-10) 110, 520, 854 0 0 11.00 0 11 00 FIXED ASSETS 12.00 Land 18, 926, 206 0 0 0 12.00 Land improvements 9, 993, 537 0 13.00 0 0 0 0 0 0 0 0 0 0 0 0 0 13.00 οĺ 14.00 Accumulated depreciation -2, 222, 155 0 14.00 297, 514, 437 15.00 Bui I di ngs 0 0 15.00 16.00 Accumulated depreciation -177, 089, 788 0 16.00 0 17.00 Leasehold improvements 17.00 0 0 18 00 Accumulated depreciation C 0 18 00 Fi xed equipment 19.00 19.00 0 20.00 Accumulated depreciation 0 20.00 0 21.00 Automobiles and trucks C 0 21.00 22.00 Accumulated depreciation 0 22.00 23.00 Major movable equipment 144, 853, 391 0 23.00 Accumulated depreciation -43, 915, 433 24.00 24.00 0 25.00 Mi nor equi pment depreci able Λ 25, 00 26.00 Accumulated depreciation 0 0 26.00 C 27.00 HIT designated Assets 0 0 0 0 27.00 0 28.00 Accumulated depreciation 0 0 28.00 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 248, 060, 195 0 30.00 OTHER ASSETS 256, 987, 405 31 00 Investments O 0 0 31 00 0 0 32.00 Deposits on Leases 0 32.00 Due from owners/officers 17, 976, 987 0 0 0 33.00 33.00 0 34.00 Other assets 19, 549, 558 0 0 34.00 0 Total other assets (sum of lines 31-34) 35.00 294, 513, 950 0 35, 00 36.00 Total assets (sum of lines 11, 30, and 35) 653, 094, 999 0 0 0 36.00 CURRENT LIABILITIES 37 00 23, 966, 715 O 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 13, 276, 726 0 38.00 Payroll taxes payable 0 39.00 39.00 0 0 Notes and Loans payable (short term) 21, 950, 000 0 40.00 40.00 0 0 Deferred income 41 00 41 00 0 42.00 Accelerated payments 22, 494, 000 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities 0 44.00 21, 082, 004 0 0 44.00 Total current liabilities (sum of lines 37 thru 44) 0 0 45.00 102, 769, 445 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 109, 872, 078 0 46.00 0 0 Notes payable 0 47.00 47.00 48 00 Unsecured Loans 0 0 0 48 00 Other long term liabilities 14, 174, 701 0 0 49.00 49.00 0 50 00 Total long term liabilities (sum of lines 46 thru 49) 124, 046, 779 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 51.00 226, 816, 224 0 0 0 51.00 CAPITAL ACCOUNTS 426, 278, 775 52.00 General fund balance 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 426, 278, 775 0 59.00 Total liabilities and fund balances (sum of lines 51 and 60.00 653, 094, 999 0 0 0 60.00

Health Financial Systems
STATEMENT OF CHANGES IN F

ncai tri	Titlancial Systems	HENDRI GRO REGIONAL HEALTH			111 E1 CG O1 1 O1 III CM3 2332 10			
STATEM	MENT OF CHANGES IN FUND BALANCES		Provi der CO	CN: 15-0005	Period: From 01/01/2020	Worksheet G-1		
					To 12/31/2020	Date/Time Pre 7/30/2021 3:0		
		General	Fund	Speci al	Purpose Fund	Endowment Fund		
		1.00	0.00	2.00	4.00	5.00		
4 00		1.00	2.00	3. 00	4. 00	5. 00	4 00	
1. 00	Fund balances at beginning of period		420, 322, 545		0)	1. 00	
2. 00	Net income (loss) (from Wkst. G-3, line 29)		5, 956, 230				2. 00	
3.00	Total (sum of line 1 and line 2)		426, 278, 775		0)	3.00	
4.00	Additions (credit adjustments) (specify)	0			0	0	4.00	
5. 00		0			0	0	5.00	
5. 00		o			0	0	6.00	
7. 00		o			0	0	7. 00	
3. 00		O			0	0	8. 00	
9. 00		O			0	0	9. 00	
10. 00	Total additions (sum of line 4-9)		0		0		10.00	
11. 00	Subtotal (line 3 plus line 10)		426, 278, 775		0		11. 00	
12. 00	Deductions (debit adjustments) (specify)	o			0	0	12.00	
13. 00	, , , , , , , , , , , , , , , , , , , ,	O			0	0	13.00	
	1	1 1			_	1		

0 14.00

14. 00		0		0		0	14.00
15. 00		0		0		0	15. 00
16.00		o		0		0	16. 00
17.00		o		0		0	17. 00
18.00	Total deductions (sum of lines 12-17)		0		0		18. 00
19.00	Fund balance at end of period per balance		426, 278, 775		o		19. 00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 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
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7. 00
8.00			0				8.00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11. 00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16. 00
17. 00			0				17. 00
18.00	Total deductions (sum of lines 12-17)	0		0			18. 00
19. 00	Fund balance at end of period per balance	0		0			19. 00
	sheet (line 11 minus line 18)						

13.00 14.00

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

		To	12/31/2020	Date/Time Pre 7/30/2021 3:0	
	Cost Center Description	I npati ent	Outpati ent	Total	O piii
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•	<u> </u>		
	General Inpatient Routine Services				
1.00	Hospi tal	42, 977, 831		42, 977, 831	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF	0		0	
7. 00	SKILLED NURSING FACILITY	0		0	
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE	40.077.004			9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	42, 977, 831		42, 977, 831	10. 00
11 00	Intensive Care Type Inpatient Hospital Services	14 222 504		14 222 504	1 11 00
11. 00 12. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	14, 333, 594		14, 333, 594	11. 00 12. 00
13. 00	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
	Total intensive care type inpatient hospital services (sum of lines	14, 333, 594		14, 333, 594	
10.00	11-15)	11,000,071		11,000,071	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	57, 311, 425		57, 311, 425	17. 00
18. 00	Ancillary services	141, 989, 189	422, 784, 620	564, 773, 809	
19. 00	Outpati ent servi ces	21, 088, 493	124, 140, 375	145, 228, 868	
20.00	RURAL HEALTH CLINIC	0	o	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	O	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	PROFESSIONAL FEES	1, 957, 411	99, 935, 188	101, 892, 599	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	222, 346, 518	646, 860, 183	869, 206, 701	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		367, 631, 175		29. 00
30. 00	ADD (SPECIFY)	0	307, 031, 173		30.00
31. 00	ADD (SECTED)				31.00
32. 00		0			32. 00
33. 00		0			33. 00
34. 00		0			34.00
35. 00		0			35. 00
36.00	Total additions (sum of lines 30-35)		O		36. 00
37.00	DEDUCT (SPECIFY)	0			37. 00
38.00		0			38. 00
39.00		0			39. 00
40.00		0			40. 00
41.00		0			41. 00
42.00	Total deductions (sum of lines 37-41)		0		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		367, 631, 175		43. 00
	to Wkst. G-3, line 4)				

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10					
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0005 Period:			Worksheet G-3		
			From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 3:0	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	0 20)		869, 206, 701	1. 00
2.00	Less contractual allowances and discounts on patients' accoun			544, 326, 331	
3.00	Net patient revenues (line 1 minus line 2)	13		324, 880, 370	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		367, 631, 175	
5. 00	Net income from service to patients (line 3 minus line 4)	,		-42, 750, 805	
	OTHER I NCOME			.=/	
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			24, 311, 773	7. 00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00				0	9. 00
10.00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			0	11. 00
	Parking lot receipts			0	
13.00	Revenue from Laundry and Linen service			0	10.00
14. 00	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters				15. 00
	Revenue from sale of medical and surgical supplies to other t	han patients		0	
	Revenue from sale of drugs to other than patients			0	
	.00 Revenue from sale of medical records and abstracts			0	10.00
	9.00 Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23. 00	Governmental appropri ati ons			0	
24. 00	OTHER REVENUE			11, 097, 827	
24. 01	OTHER			49	
24. 50	COVI D-19 PHE Fundi ng			13, 297, 386	
25. 00	Total other income (sum of lines 6-24)			48, 707, 035	
26. 00	Total (line 5 plus line 25)			5, 956, 230	
	OTHER EXPENSES (SPECIFY)			0	
	28.00 Total other expenses (sum of line 27 and subscripts)			0	
29. 00	Net income (or loss) for the period (line 26 minus line 28)		l	5, 956, 230	∠9. 00

Heal th	Financial Systems HENDRICKS REGION	NAL HEALTH	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0005	Peri od: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Pre 7/30/2021 3:0	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
1 00	CAPITAL FEDERAL AMOUNT				
1. 00 1. 01	Capital DRG other than outlier			1, 392, 993 0	1. 00 1. 01
2. 00	Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments			104, 582	
2. 01	Model 4 BPCI Capital DRG outlier payments				2. 01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)				1
4.00	Number of interns & residents (see instructions)			54. 43 0. 00	1
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			0	6. 00
	1.01) (see instructions)			I	
7. 00	Percentage of SSI recipient patient days to Medicare Part A p	oatient days (Worksheet E	, part A line	1. 04	7. 00
0.00	30) (see instructions)	inti ana)		18. 65	8. 00
8. 00 9. 00	Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8			19. 69	1
10. 00	Allowable disproportionate share percentage (see instructions	:)		4. 07	
11. 00				56, 695	
12. 00	, , , , , , , , , , , , , , , , , , , ,			1, 554, 270	
	DART II DAVMENT IMPED DEACONARIE COCT	1. 00			
1. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)			Ö	3.00
4.00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00	
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0	2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3. 00	
4.00	Applicable exception percentage (see instructions)			0.00	1
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see in			0.00	1
7.00	Adjustment to capital minimum payment level for extraordinary	/ circumstances (line 2 x	(line 6)	0	7. 00 8. 00
8. 00 9. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli	cable)		0	9.00
10. 00	Current year comparison of capital minimum payment level to c		less line 0)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over of			0	11.00
11.00	Worksheet L, Part III, line 14)			ı	11.00
12.00				0	12.00
13.00	Current year exception payment (if line 12 is positive, enter	the amount on this line	e)	0	13. 00
14. 00	Carryover of accumulated capital minimum payment level over o	capital payment for the f	following period	0	14. 00
45.05	(if line 12 is negative, enter the amount on this line)			-	45.00
15. 00	Current year allowable operating and capital payment (see ins	STRUCTIONS)		0	15. 00 16. 00
16.00	Current year operating and capital costs (see instructions) Current year exception offset amount (see instructions)			0	
17.00	Tourient year exception oriset amount (see instructions)			Ü	17.00