## HENRY COUNTY MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

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: 15-0030 Worksheet S Peri od. From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: То 7/30/2021 9:15 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 7/30/2021 Time: 9:15 am Manually prepared cost report use only 2. [ ]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. 3 0 Ē 4 [ 6. Date Received: 7. Contractor No. 10. NPR Date: Contractor 5. ]Cost Report Status Γ 

 (1) As Submitted
 7. Contractor No.
 11. Contractor's Vendor Code:
 4

 (2) Settled without Audit 8.
 [N] Initial Report for this Provider CCN
 11. Contractor's Contractor's Vendor Code:
 4

 (3) Settled with Audit 9.
 [N] Final Report for this Provider CCN
 number of times reopened = 0-9.

 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HENRY COUNTY MEMORIAL HOSPITAL (15-0030) for the cost reporting period beginning 01/01/2020 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] have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Si gned) DARIN BROWN Officer or Administrator of Provider(s) CF0 Title

(Dated when report is electronically signed.)

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-7,633	-60, 496	0	-106, 695	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		748, 700		0	10.00
10.01	RURAL HEALTH CLINIC II	0		424, 969		0	10.01
10. 02	RURAL HEALTH CLINIC III	0		76, 764		0	10.02
200.00	Total	0	-7, 633	1, 189, 937		- 106, 695	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.

	AL AND HOSPITAL HEALTH CARE COMPLEX		Provio	der CCN:		Period: From 01/01/ To 12/31/	2020	Workshe Part I Date/Ti 7/30/20	me Pre	epared
	1.00	2.00		3.00			4.00			
00	Hospital and Hospital Health Care Co Street: 1000 NORTH 16TH STREET	PO Box:								1.0
00	City: NEW CASTLE	State: IN	Zip Cod	e: 47392-	- Count	ty: HENRY				2.0
00		Component Name	CCN	CBSA	Provi der		Payme	ent Syst	em (P,	2.1
			Number	Number	Туре	Certified		, 0, or		
							V	XVIII	XI X	]
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component		450000	00015		07/04/400/	N		0	
0	Hospi tal	HENRY COUNTY MEMORIAL HOSPITAL	150030	99915	1	07/01/1996	N	P	0	3.
0	Subprovider - IPF	IN SIT THE								4.
0	Subprovider - IRF									5.
0	Subprovider - (Other)				1					6.
0	Swing Beds - SNF				1					7.
0	Swing Beds - NF								1	8.
0	Hospital-Based SNF								1	9.
00	Hospital-Based NF									10.
00	Hospital-Based OLTC									11.
00	Hospital-Based HHA	HCMH HOME CARE	157430	99915		06/14/1995	N	P	N	12.
00	Separately Certified ASC									13.
00	Hospital-Based Hospice	HOSP-BASED HOSPICE	151564	99915		08/31/1998				14.
00	Hospital-Based Health Clinic - RHC	NEW CASTLE FAMILY AND	158520	99915		04/11/2017	N	0	0	15.
01		INTERNAL MED	10000	00015		10/04/0017				4-
01	Hospital-Based Health Clinic - RHC	NCFIM - NORHTFIELD PARK	158525	99915		12/04/2017	N	0	0	15.
02	Hospital-Based Health Clinic - RHC	CAMBRIDGE CITY FAMILY HEALTH PARTNER	158556	99915		06/02/2020	N	0	0	15.
00	Hospital-Based Health Clinic - FQHC									16.
00	Hospital -Based (CMHC) I									17.
00	Renal Dialysis									18
	Other				1					19
	·					·		· _		
						From:		To	:	
	1					1.00		2.0	00	
	Cost Reporting Period (mm/dd/yyyy)					1.00 01/01/20			00	
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					1.00		2.0	00	
					1.00	1.00 01/01/20 9		2. ( 12/31/	00 /2020	
					1.00	1.00 01/01/20		2.0	00 /2020	
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00 00 00 01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is if disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section 9 hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in column 2, "Y" for yes or "I reporting period? Conter in column 2, "Y" for yes or "I reporting period occurring on or af- Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "I cost reporting period prior to 0ctol or "N" for no, for the portion of the October 1. Did this hospital receive a geographer rural as a result of the OMB standard adopted by CMS in FY2015? Enter in column 2, "Y" for yes or "N" for reporting period occurring on or af- tin column 2, "Y" for yes or "N" for the portion of the cost reporting for the portion of the cost reporting for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or af- Does this hospital contain at least	ustment, in accordance wi or yes or "N" for no. Is \$412.106(c)(2)(Pickle amo or yes or "N" for no. ncompensated care paymen umn 1, "Y" for yes or "N' eriod occurring prior to "for no for the portion ter October 1. (see insti trequires final uncompen- port settlement? (see in "for no, for the portion er 1. Enter in column 2, he cost reporting period hic reclassification from rds for delineating stati- column 1, "Y" for yes or ng period prior to Octobe no for the portion of the ter October 1. (see insti 100 but not more than 40	th 42 CF this endment ts for th 'for no October n of the ructions) issted ca astructio on of the "Y" for on or af m urban t stical a "N" for er 1. Ent tuctions) 29 beds (	R is for 1. cost re ns) yes ter o reas no er as	Y Y N	1.00 01/01/20 9 2.00 N Y N		2. ( 12/31/ 3. (	00 /2020 00 00	211. 222. 222. 222.
00 00 01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is if disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section 9 hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "I reporting period occurring on or af- Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "I cost reporting period prior to Octol or "N" for no, for the portion of the October 1. Did this hospital receive a geographer rural as a result of the OMB standar adopted by CMS in FY2015? Enter in column 2, "Y" for yes or "N" for reporting period occurring on or af- Does this hospital contain at least counted in accordance with 42 CFR 4	ustment, in accordance wi or yes or "N" for no. Is \$412.106(c)(2)(Pickle amo or yes or "N" for no. ncompensated care paymen umn 1, "Y" for yes or "N' eriod occurring prior to "for no for the portion ter October 1. (see insti trequires final uncompen- port settlement? (see in "for no, for the portion er 1. Enter in column 2, he cost reporting period hic reclassification from rds for delineating stati- column 1, "Y" for yes or ng period prior to Octobe no for the portion of the ter October 1. (see insti 100 but not more than 40	th 42 CF this endment ts for th 'for no October n of the ructions) issted ca astructio on of the "Y" for on or af m urban t stical a "N" for er 1. Ent tuctions) 29 beds (	R is for 1. cost re ns) yes ter o reas no er as	Y Y N	1.00 01/01/20 9 2.00 N Y N		2. ( 12/31/ 3. (	00 /2020 00 00	211. 222. 222. 222.
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is i disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section 3 hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "I reporting period occurring on or af- Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "I cost reporting period prior to Octol or "N" for no, for the portion of the October 1. Did this hospital receive a geographerural as a result of the OMB standard adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or af- Does this hospital contain at least counted in accordance with 42 CFR 4 yes or "N" for no.	ustment, in accordance wi or yes or "N" for no. Is 5412.106(c)(2)(Pickle amo or yes or "N" for no. ncompensated care paymen umn 1, "Y" for yes or "N' eriod occurring prior to "for no for the portion ter October 1. (see instr t requires final uncomper aport settlement? (see in "for no, for the portion oper 1. Enter in column 2, ne cost reporting period hic reclassification from rds for delineating stati column 1, "Y" for yes or ng period prior to Octobe no for the portion of the ter October 1. (see instri- tion the portion of the column 1, "Y" for yes or ng period prior to Octobe no for the portion of the 100 but not more than 40 [2.105)? Enter in column	th 42 CF this endment ts for th 'for no October n of the "uctions) hsated ca structio on of the "Y" for on or af m urban t stical a "N" for er 1. Ent he cost '99 beds ( 3, "Y" f	R is for 1. cost re ns) yes ter o reas no er as or	Y Y N	1.00 01/01/20 9 2.00 N Y N N		2. ( 12/31/ 3. (	00 /2020 00 00	21. 22. 22. 22. 22.
00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is i disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section 3 hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in column the portion of the cost reporting period occurring on or af- Is this a newly merged hospital than payments to be determined at cost re- Enter in column 1, "Y" for yes or "I cost reporting period prior to Octolo or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard adopted by CMS in FY2015? Enter in col for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or af- Does this hospital contain at least counted in accordance with 42 CFR 4- yes or "N" for no. Which method is used to determine Me	ustment, in accordance wi or yes or "N" for no. Is 5412.106(c)(2)(Pickle amo or yes or "N" for no. ncompensated care paymen mm 1, "Y" for yes or "N' eriod occurring prior to "for no for the portion ter October 1. (see instit t requires final uncomper eport settlement? (see in "for no, for the portion of the portion of the port settlement? (see in "for no, for the portion of the portion of the cost reporting period hic reclassification from rds for delineating stati column 1, "Y" for yes or ng period prior to Octobe no for the portion of the ter October 1. (see instit 100 but not more than 44 12.105)? Enter in column edicaid days on lines 24	th 42 CF this endment ts for th 'for no October n of the "uctions) nsated ca structio on of the "Y" for on or af m urban t stical a "N" for er 1. Ent ne cost "uctions) 29 beds ( 3, "Y" f	R is for 1. cost re ns) yes ter o reas no er as or 5	Y Y N	1.00 01/01/20 9 2.00 N Y N		2. ( 12/31/ 3. (	00 /2020 00 00	21. 22. 22. 22. 22.
00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is individe a set of the se	ustment, in accordance wi or yes or "N" for no. Is 5412.106(c)(2)(Pickle amo or yes or "N" for no. ncompensated care paymen mm 1, "Y" for yes or "N' eriod occurring prior to " for no for the portion ter October 1. (see instit requires final uncomper eport settlement? (see in " for no, for the portion per 1. Enter in column 2, he cost reporting period hic reclassification from rds for delineating stati column 1, "Y" for yes or g period prior to Octobe no for the portion of the ter October 1. (see instit 100 but not more than 44 12.105)? Enter in column edicaid days on lines 24 of admission, 2 if censu	th 42 CF this endment ts for th 'for no October n of the ructions) nsated ca on of the "Y" for on or af m urban t stical a "N" for er 1. Ent he cost ructions) 29 beds ( 3, "Y" f	R is for 1. cost re ns) yes ter o reas no er as for 5 or 3	Y Y N	1.00 01/01/20 9 2.00 N Y N N		2. ( 12/31/ 3. (	00 /2020 00 00	20. 21. 22. 22. 22. 22. 22. 22. 22.
00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is i disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section 3 hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in column the portion of the cost reporting period occurring on or af- Is this a newly merged hospital than payments to be determined at cost re- Enter in column 1, "Y" for yes or "I cost reporting period prior to Octolo or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard adopted by CMS in FY2015? Enter in col for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or af- Does this hospital contain at least counted in accordance with 42 CFR 4- yes or "N" for no. Which method is used to determine Me	ustment, in accordance wi or yes or "N" for no. Is \$412.106(c)(2)(Pickle amo or yes or "N" for no. compensated care paymen umn 1, "Y" for yes or "N' eriod occurring prior to "for no for the portion ter October 1. (see insti "for no, for the portion ter october 1. (see insti "for no, for the portion er 1. Enter in column 2, he cost reporting period hic reclassification from rds for delineating stati column 1, "Y" for yes or ng period prior to Octobe no for the portion of the ter October 1. (see insti 100 but not more than 44 12.105)? Enter in column edicaid days on lines 24 of admission, 2 if censu of identifying the days	th 42 CF this endment ts for th 'for no October n of the "uctions) sated ca astructio on of the "Y" for on or af m urban t stical a "N" for er 1. Ent tuctions) 29 beds ( 3, "Y" f and/or 2 us days, in this	R is for 1. cost re ns) yes ter o reas no er as for 5 or 3	Y Y N	1.00 01/01/20 9 2.00 N Y N N		2. ( 12/31/ 3. (	00 /2020 00 00	21 22 22 22 22 22

Health Financial Systems HENRY COL	JNTY MEMORIA	L HOSPI TAL			In Lieu	of For	m CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC	CN: 15-0030	Period: From 01/0		Workshe Part I	eet S-2	2
	_				1/2020	Date/Ti	ime Pre 021 9:1	
	In-State Medicaid	In-State Medicaid	Out-of State	Out-of State	Medicai HMO day		ther di cai d	
	pai d days	eligible	Medi cai d	Medi cai d			days	
		unpai d	paid days	eligible				
	1.00	days 2.00	3.00	unpai d 4. 00	5.00		5.00	-
24.00 If this provider is an IPPS hospital, enter the	232			4.00		170		24.00
in-state Medicaid paid days in column 1, in-state								
Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3,								
out-of-state Medicaid eligible unpaid days in column	n							
4, Medicaid HMO paid and eligible but unpaid days in	n							
column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state	0	0	0	0		0		25.00
Medicaid paid days in column 1, the in-state	-	-						
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/R	ural S I	Date of 2.0		
26.00 Enter your standard geographic classification (not v		at the be	ginning of		1	Ζ.	00	26.00
cost reporting period. Enter "1" for urban or "2" fo		at the second	- d of + ···		1			07.00
27.00 Enter your standard geographic classification (not v reporting period. Enter in column 1, "1" for urban of				st	1			27.00
enter the effective date of the geographic reclassi	fication in	column 2.						
35.00 If this is a sole community hospital (SCH), enter th	ne number of	periods S	CH status i	n	0			35.00
effect in the cost reporting period.				Begi n	ni na:	Endi	na:	
24.00 Enter applicable beginning and onding dates of SCH.	status Sub	orint line	24 for num	1.		2.		26.00
36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent da		script ine	30 101 1101	ber				36.00
37.00 If this is a Medicare dependent hospital (MDH), ente	er the numbe	er of perio	ds MDH stat	us	1			37.00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for	the MDH tran	nsitional p	avment in					37.01
accordance with FY 2016 OPPS final rule? Enter "Y" t								
instructions) 38.00 If line 37 is 1, enter the beginning and ending date	es of MDH st	atus If I	ine 37 is	01/01	/2020	12/31	/2020	38.00
greater than 1, subscript this line for the number of				01701	2020	12/51	/ 2020	50.00
enter subsequent dates.				X			(81	
				Y/ 1.1		Y/ 2.0		-
39.00 Does this facility qualify for the inpatient hospita	al payment a	adjustment	for low vol					39.00
hospitals in accordance with 42 CFR §412.101(b)(2)(i				mn				
1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i				es				
or "N" for no. (see instructions)			2					
40.00 Is this hospital subject to the HAC program reduction						Ν	1	40.00
"N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October			yes or N	ror				
				I	V	XVIII	XI X	
Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
45.00 Does this facility qualify and receive Capital payme	ent for disp	proporti ona	te share in	accordance	e N	N	N	45.00
with 42 CFR Section §412.320? (see instructions)								44.00
46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46.00
Pt. III.				-				
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS					N	N	N	47.00
48.00 Is the facility electing full federal capital paymer Teaching Hospitals	it: Eiitei	i ioi yes		10.	N	N	N	48.00
56.00 Is this a hospital involved in training residents in								56.00
"N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for			(or subsequ	ent CR), M4	<b>\</b>			
57.00 If line 56 is yes, is this the first cost reporting			esidents in	approved				57.00
GME programs trained at this facility? Enter "Y" for	or yes or "N	l" for no i	n column 1.	lf column				
is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is '								
"N", complete Wkst. D, Parts III & IV and D-2, Pt. I			. <u>с</u> . т. С	51 01111 2 1 3				
58.00 If line 56 is yes, did this facility elect cost reir	mbursement f	°or physici	ans' servic	es as				58.00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 59.00 Are costs claimed on line 100 of Worksheet A? If ye			. Pt. I		N			59.00
	, comprote		,			1	1	

Health Financial Systems HENRY COUN	TY MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CO	CN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Pre 7/30/2021 9:1	pared:
			NAHE 413.85 Y/N	5 Worksheet A Line #	Pass-Through Qualification Criterion Code	
		-	1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in col	85? (s umn 1. CR) NAHI	see If column 1	N			60.00
	Y/N	IME	Direct GME		Direct GME	
	1.00	2.00	3.00	4.00	5.00	
<ul> <li>61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>61.01 Enter the average number of unweighted primary care</li> </ul>	N			0.00	0.00	61.00
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 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	(1.10
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61. 20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Ser						
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct		d in this cost	reporting p	eriod for which		62.00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC proc	gram. (s	see instructio		to your hospital	0.00	62.01
63.00 Has your facility trained residents in Nonprovider se "Y" for yes or "N" for no in column 1. If yes, completing	ettings	during this o			N	63.00

	Financial Systems AL AND HOSPITAL HEALTH CARE COMP		NTY MEMORIAL HOSPITAL ATA Provider C	CN: 15-0030 Pe	eri od:	Worksheet S-2	2552-1 :
				Fr Tc	rom 01/01/2020 0 12/31/2020	Part I Date/Time Pre 7/30/2021 9:1	pared 5 am
				Unweighted	Unwei ghted	Ratio (col.	
				FTEs	FTEs in	1/ (col. 1 +	
				Nonprovider Site	Hospi tal	col. 2))	
				1.00	2.00	3.00	1
	Section 5504 of the ACA Base Yea	r FTE Residents in N	lonprovider Settings-				
	period that begins on or after J			-			
1.00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.0
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
		5		FTEs	FTEsin	3/ (col. 3 +	
				Nonprovi der	Hospi tal	col. 4))	
				Site			-
00	Enton in column 1 if line (2)	1.00	2.00	3.00	4.00	5.00	
5. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00 Unweighted FTEs	0.00 Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
				Nonprovider Site	Hospi tal	col. 2))	
	Contion EEO/ of the ADA D	Voor FTF Deel hat	n Nonnerd den Cului	1.00	2.00	3.00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	JSEITECTIVE f	or cost report	ing periods	
. 00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.0
	(column 1 divided by (column 1 +	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
		g. am Mamo	g. a oodo	FTEs	FTEs in	3/ (col . 3 +	
				Nonprovi der	Hospi tal	col. 4))	
				Site		_	-
. 00	Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 0.000000	17
-	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						

Heal th	Financial Systems HENRY COUNTY MEMORIAL HOSPITAL	In Lieu	u of Form CMS-	2552-10
HOSPI T		eriod: com 01/01/2020 o 12/31/2020	Worksheet S-2 Part I Date/Time Pre 7/30/2021 9:1	epared:
		1.00	0 2.00 3.00	_
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub	provider? N		70.00
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reportin	no. (see hi ng no.	0	71.00
75 00	(see instructions) Inpatient Rehabilitation Facility PPS			75 00
	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N		75.00
/6.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes o no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y indicate which program year began during this cost reporting period. (see instructions)	r "N" for with 42	0	76.00
			1.00	-
	Long Term Care Hospital PPS		N	00.00
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? Enter	N N	80.00 81.00
86.00	<u>TEFRA Providers</u> Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sectio		N	85.00 86.00
	<pre>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.</pre>		Ν	87.00
		V 1.00	XI X 2. 00	_
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Y	90.00
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N	Y	91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		Ν	92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applicable column. 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.	Ν	Ν	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	Ν	Ν	94.00
	IF line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N	0. 00 N	95.00 96.00
	If line 96 is "Y", enter the reduction percentage in the applicable column. 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.	0. 00 Y	0. 00 Y	97.00 98.00
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98. 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.	Y	Y	98.02
98. 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	Ν	Ν	98.03
98.04	for title V, and in column 2 for title XIX. 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	Ν	Ν	98.04
98. 05	in column 2 for title XIX. 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	Y	Y	98.05
98.06	column 2 for title XIX. 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.	Y	Y	98.06
105.00	Rural Providers Does this hospital qualify as a CAH?	N		105.00
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an	Ν		107.00
	approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			

Health Financial Systems HENRY COUNTY MEMO	RIAL HOSPITAL		In Lieu	In Lieu of Form CMS-255		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C			Worksheet S-2 Part I Date/Time Pre 7/30/2021 9:1	epared:	
			V 1.00	XI X 2.00	-	
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	edul e? See 42	Ν		108.00	
	Physi cal	Occupati onal	Speech	Respi ratory		
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3.00 N	4.00 N	109.00	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						
110.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	"Y" for yes or	"N" for no. I	F yes,	1.00 N	110.00	
			1.00	2.00	-	
111.00 If this facility qualifies as a CAH, did it participate in THealth Integration Project (FCHIP) demonstration for this com "Y" for yes or "N" for no in column 1. If the response to contintegration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for an for tele-health services.	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N	2.00	111.00	
		1.00	2.00	3.00	-	
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting 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 cear participation in the demonstration, if applicable.	period? s "Y", enter he	N			112.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, I in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) 93" percent (includes	N		C	0115.00	
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00	
117.00 Is this facility legally-required to carry malpractice insu	rance? Enter	Y			117.00	
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr		1			118.00	
		Premi ums	Losses	Insurance		
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3.00	0118.01	
			1.00			
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scher and amounts contained therein.			<u>1.00</u> N	2.00	118.02	
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified that have a special and applicable amendment Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, "Y ualifies for t	(" for yes or he Outpatient	Ν	Ν	119.00 120.00	
121.00 Did this facility incur and report costs for high cost impla	antable device	es charged to	Υ		121.00	
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as det Act?Enter "Y" for yes or "N" for no in column 1. If column the Weakback A Line purpher where there taxes are included			Ν		122.00	
the Worksheet A line number where these taxes are included. Transplant Center Information					1	
125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and "N"	for no. If	Ν		125.00	
126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 3		fication date			126.00	
127.00 If this is a Medicare certified heart transplant center, en	ter the certif	ication date			127.00	
in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, en		ication date			128.00	
in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		cation date in			129.00	

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLE	HENRY COUNTY					u of Form CMS Worksheet S	-2
				From To	01/01/2020 12/31/2020		
					1.00	2.00	_
0.00 If this is a Medicare certified pa	ancreas transplant cer	nter, enter the cer	ti fi cati or	1	1.00	2.00	130. (
date in column 1 and termination ( 1.00 If this is a Medicare certified in	ntestinal transplant o	center, enter the c	erti fi cati	on			131. (
date in column 1 and termination			St				100
2.00 If this is a Medicare certified is in column 1 and termination date,			TCation da	ite			132.
3.00 Removed and reserved 4.00 If this is an organ procurement of and termination date, if applicable		ter the OPO number	in column	1			133. 134.
All Providers 0.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	"N" for no in column í	1. If yes, and home	office co		Y		140. (
1.00 If this facility is part of a cha	in organization enter	2.00 r on lines 141 thro	ough 143 th	ne name	3.00	of the home	
office and enter the home office				le fiance		s of the nome	
1.00 Name:	Contractor's Nam	ne:	Contra	actor's	Number:		141.0
2.00Street: 3.00City:	PO Box: State:		Zip Co	ode:			142. ( 143. (
						1.00	_
4.00 Are provider based physicians' cos	sts included in Worksh	heet A?				Y	144. (
				-	1.00	2.00	-
5.00 If costs for renal services are cl inpatient services only? Enter "Y	" for yes or "N" for r	no in column 1. If	column 1 i		1.00	2.00	145.
no, does the dialysis facility in period? Enter "Y" for yes or "N"		ation for this cost		1			
5.00 Has the cost allocation methodolog	gy changed from the pr				Ν		146.
	gy changed from the pr n column 1. (See CMS F			lf	N		146.
6.00Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2.	Pub. 15-2, chapter	40, §4020)	lf	N	1.00	
<ul> <li>6. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/or 7. 00 Was there a change in the statisti 8. 00 Was there a change in the order or</li> </ul>	gy changed from the pr n column 1. (See CMS F <u>dd/yyyy) in column 2.</u> ical basis? Enter "Y" f allocation? Enter "Y	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f	40, §4020) • no. • or no.			1.00 N N	147.
<ul> <li>6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/or 7.00 Was there a change in the statisti 8.00 Was there a change in the order or</li> </ul>	gy changed from the pr n column 1. (See CMS F <u>dd/yyyy) in column 2.</u> ical basis? Enter "Y" f allocation? Enter "Y	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y	40, \$4020) - no. For no. res or "N"	for no.		N N N	147. 148. 149.
<ul> <li>6. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/or 7. 00 Was there a change in the statisti 8. 00 Was there a change in the order or</li> </ul>	gy changed from the pr n column 1. (See CMS F <u>dd/yyyy) in column 2.</u> ical basis? Enter "Y" f allocation? Enter "Y	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f	40, §4020) • no. • or no.	for no.		N N	147. 148. 149.
<ul> <li>6. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d</li> <li>7. 00 Was there a change in the statististististication of the statistication of the statis</li></ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption fro	40, \$4020) - no. - ro. - ro	for no. 3 i cati or	Title V 3.00 n of the low	N N Title XIX 4.00 ver of costs	147. 148. 149.
<ul> <li>3.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/or 7.00 Was there a change in the statisti 3.00 Was there a change in the order or 9.00 Was there a change to the simplification Does this facility contain a prov or charges? Enter "Y" for yes or</li> </ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption fro	40, \$4020) - no. - ro. - ro	for no. 3 i cati or	Title V 3.00 n of the low	N N Title XIX 4.00 ver of costs	147. 148. 149.
<ul> <li>6. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/or 7. 00 Was there a change in the statisti 3. 00 Was there a change in the order or 9. 00 Was there a change to the simplifient Does this facility contain a prov or charges? Enter "Y" for yes or 5. 00 Hospital 6. 00 Subprovider - IPF</li> </ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A	40, \$4020) r no. ror no. res or "N" Part I 2.00 pm the appl and Part	for no. 3 i cati or	Title V 3.00 n of the low 2 42 CFR §41	N N Title XIX 4.00 ver of costs 3.13)	147. 148. 149. 155. 155. 156.
<ul> <li>6. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d</li> <li>7. 00 Was there a change in the statistic 8. 00 Was there a change in the order of 9. 00 Was there a change to the simplific</li> <li>Does this facility contain a provor charges? Enter "Y" for yes or 5. 00 Hospital</li> <li>6. 00 Subprovider - IPF</li> <li>7. 00 Subprovider - IRF</li> </ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N	40, \$4020) r no. ror no. res or "N" Part I 2.00 om the appl A and Part N	for no. 3 i cati or	TitleV 3.00 n of the low e 42 CFR §41 N	N N Title XIX 4.00 ver of costs 3.13) N	147. 148. 149. 155. 155. 156. 157.
<ul> <li>6. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/or 7. 00 Was there a change in the statistic 8. 00 Was there a change in the order or 9. 00 Was there a change to the simplified Does this facility contain a prov or charges? Enter "Y" for yes or 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER</li> </ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N N N	40, \$4020) - no. - ro. - ro	for no. 3 i cati or	TitleV 3.00 n of the low e 42 CFR §41 N N N	N N TitleXIX 4.00 ver of costs 3.13) N N N	147. 148. 149. 155. 155. 156. 157. 158.
<ul> <li>5. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d 7. 00 Was there a change in the statistic 3. 00 Was there a change in the order or 7. 00 Was there a change to the simplific Does this facility contain a prov or charges? Enter "Y" for yes or 5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF</li> </ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N N	40, \$4020) - no. - ro. - ro	for no. 3 i cati or	Title V 3.00 n of the low e 42 CFR §41 N	N N Title XIX 4.00 ver of costs 3.13) N N	147. 148. 149. 155. 156. 156. 157. 158. 159.
<ul> <li>5. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d</li> <li>7. 00 Was there a change in the statistical 3. 00 Was there a change in the order or 9. 00 Was there a change to the simplifical boos this facility contain a prov or charges? Enter "Y" for yes or 5. 00 Subprovider - IPF 7. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF</li> <li>5. 00 HOME HEALTH AGENCY</li> </ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N N N	40, \$4020) r no. ror no. res or "N" Part I 2.00 pm the appl and Part N N N	for no. 3 i cati or	Title V 3.00 n of the low e 42 CFR §41 N N N N	N N Title XIX 4.00 /er of costs 3.13) N N N	147. 148. 149. 155. 156. 157. 158. 157. 158. 159. 160.
<ul> <li>3. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d)</li> <li>7. 00 Was there a change in the statistication of the statistication</li></ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N N N	40, \$4020) Tono. Tor no. Tor no. To	for no. 3 i cati or	Title V 3.00 n of the low e 42 CFR §41 N N N N N	N N Title XIX 4.00 /er of costs 3.13) N N N N N	147. 148. 149. 155. 156. 157. 158. 157. 158. 159. 160.
6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo "N" for no for each co	Pub. 15-2, chapter for yes or "N" for y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N N N N N	40, \$4020) no. for no. res or "N" Part 1 2.00 m the appl A and Part N N N N N N N	for no. 3 i cati or B. (See	TitleV 3.00 n of the low e 42 CFR §41 N N N N N N N N	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161.
<ul> <li>6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d)</li> <li>7.00 Was there a change in the statistic 8.00 Was there a change in the order of 9.00 Was there a change to the simplific Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital</li> <li>6.00 Subprovider - IPF</li> <li>7.00 Subprovider - IRF</li> <li>8.00 SUBPROVIDER</li> <li>9.00 SNF</li> <li>0.00 HOME HEALTH AGENCY</li> <li>1.00 CMHC</li> </ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo "N" for no for each co "N" for no for each co	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption froc omponent for Part A N N N N N N N N N	40, \$4020) Tono. Tor no. Tor no. Tes or "N" Part I 2.00 m the appl and Part N N N N N N N N N N N N N	for no. 3 i cati or B. (See	Title V 3.00 n of the low e 42 CFR §41 N N N N N N N S CBSAS?	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N N N N N N N N N	155. 156. 157. 158. 159. 160. 161. 165.
<ul> <li>b. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d 7.00 Was there a change in the statisti 8.00 Was there a change in the order or 9.00 Was there a change to the simplific Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 5.00 HOME HEALTH AGENCY 1.00 CMHC</li> <li>Multicampus 5.00 Is this hospital part of a Multication</li> </ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo "N" for no for each co	Pub. 15-2, chapter for yes or "N" for y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N N N N N	40, \$4020) Tono. Tor no. Tor no. Tes or "N" Part I 2.00 m the appl and Part N N N N N N N N N N N N N	for no. 3 i cati or B. (See	Title V 3.00 n of the low e 42 CFR §41 N N N N N N N S CBSAS?	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
<ul> <li>00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d 2.00 Was there a change in the statisti 3.00 Was there a change in the order of 2.00 Was there a change to the simplifit Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IRF 5.00 SUBPROVIDER 5.00 SUBPROVIDER 5.00 SUBPROVIDER 5.00 CMHC</li> <li>Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.</li> </ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo "N" for no for each co "N" for no for each co ampus hospital that ha Name	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N N N N N N N N N N N N N	40, \$4020) - no. - ro. - ro	for no. i cati or B. (See fferent Zi p. Coc	Title V 3.00 n of the low e 42 CFR §41 N N N N N N N N N N N N N	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N T.00 FTE/Campus 5.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
<ul> <li>b. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d 2.00 Was there a change in the statisti 3.00 Was there a change in the order or 0.00 Was there a change to the simplifient on the statistical data of the statistical on the statistical data of the statistical data of the statistical on the statistical data of the statistical dat</li></ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo "N" for no for each co "N" for no for each co ampus hospital that ha Name	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N N N N N N N N N N N N N	40, \$4020) - no. - ro. - ro	for no. i cati or B. (See fferent Zi p. Coc	Title V 3.00 n of the low e 42 CFR §41 N N N N N N N N N N N N N	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N T.00 FTE/Campus 5.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 161. 165.
<ul> <li>b. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d 7. 00 Was there a change in the statisti 8. 00 Was there a change in the order or 9. 00 Was there a change to the simplific Does this facility contain a prov or charges? Enter "Y" for yes or 5. 00 Hospital 9. 00 Subprovi der - IPF 7. 00 Subprovi der - IRF 8. 00 SUBPROVI DER 9. 00 SNF 9. 00 HOME HEALTH AGENCY 1. 00 CMHC</li> <li>Multicampus 5. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)</li> </ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies for "N" for no for each co "N" for no for each co	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N N N N as one or more camp County 1.00 merican Recovery ar	40, \$4020) To no. For no. F	for no. 3 i cati or B. (See fferent Zip Coc 3.00	Title V 3.00 n of the low e 42 CFR §41 N N N N N N N CBSAs? de CBSA 4.00	N N N Title XIX 4.00 /er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166.
<ul> <li>3. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d</li> <li>7. 00 Was there a change in the statisti</li> <li>3. 00 Was there a change in the order of</li> <li>9. 00 Was there a change to the simplified</li> <li>Does this facility contain a provor charges? Enter "Y" for yes or</li> <li>5. 00 Hospital</li> <li>5. 00 Subprovider - 1PF</li> <li>7. 00 Subprovider - 1RF</li> <li>8. 00 SUBPROVI DER</li> <li>9. 00 SNF</li> <li>0. 00 HME HEALTH AGENCY</li> <li>1. 00 CMHC</li> <li>Multicampus</li> <li>5. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)</li> <li>Heal th Information Technology (HI</li> <li>7. 00 Is this provider a meaningful user</li> <li>8. 00 If this provider is a CAH (line 10)</li> </ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies for "N" for no for each co "N" for no for each co	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" for yes or "N" for yes or "N" for Part A 1.00 or an exemption froc omponent for Part A N N N N N N N N N N N N N	40, \$4020) To no. for no. for no. for no. res or "N" Part f 2.00 m the appl N N N N N N N N N	for no. i cati or B. (See fferent Zip Coo 3.00 tment Ac	Title V 3.00 n of the low e 42 CFR §41 N N N N N N N CEBSAS? de CBSA 4.00	N N N Title XIX 4.00 //er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166. 165.
<ul> <li>6. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d 7. 00 Was there a change in the statisti 8. 00 Was there a change in the order or 9. 00 Was there a change to the simplific Does this facility contain a prov or charges? Enter "Y" for yes or 5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC</li> <li>Multicampus 5. 00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.</li> <li>6. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)</li> </ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies for "N" for no for each co "N" for no for each co	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" for y" for yes or "N" for Part A 1.00 or an exemption from or an exemption for or part A N N N N N N N N N N N N N	40, \$4020) Torno. Torno	for no. i cati or B. (See fferent Zip Coc 3.00 tment Ac , Y"), er for a h	Title V 3.00 n of the low e 42 CFR §41 N N N N N N N N S CBSAS? de CBSA 4.00 ct ct ter the	N N N Title XIX 4.00 /er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.

Health Financial Systems H	ENRY COUNTY MEMORI	AL HOSPITAL	In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFIC	CATION DATA		Period: From 01/01/2020	Worksheet S-2 Part I	2
			To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning d period respectively (mm/dd/yyyy)	late and ending dat	te for the reporting			170.00
			1.00	2.00	
171.00 If line 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			N	(	171.00
"Y" for yes and "N" for no in column 1. If c 1876 Medicare days in column 2. (see instruc	olumn 1 is yes, er		n		

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet S- Part II Date/Time Pro 7/30/2021 9:	epared:
				Y/N 1.00	Date 2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. Ent			
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					_
	Provider Organization and Operation Has the provider changed ownership immediately prior to the	boginning of	the east	N		1.00
. 00	reporting period? If yes, enter the date of the change in co					1.00
	roporting portour region and and an ango re or		Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.00
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other	ffices, drug er or its f the board	N			3.00
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differ	or Compiled, ilable in	Y	A		4.00
. 00	those on the filed financial statements? If yes, submit reco		IN			5.00
			•	Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities	16		- N		
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	IT yes, IS T	ne provider i	s N		6.00
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a		d during the	N N		7.00 8.00
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved of	araduate medi	cal education	n N		9.00
	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or	S.		N		10.00
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.00
					Y/N	
					1.00	
	Bad Debts		+!			12.00
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			cost reporting	Y N	12.00
4.00	If line 12 is yes, were patient deductibles and/or co-paymer	nts waived? I	fyes, see in	nstructions.	Ν	14.00
5 00	Bed Complement Did total beds available change from the prior cost reportin	na period?lf	ves see in	structions	N	15.00
0.00	bra total boas available change from the piror cost reportin		t A	Par		10.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	-
5.00	<u>PS&amp;R Data</u> Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	Y	05/04/2021	Y	05/04/2021	16.00
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Ν		N		17.00
3. 00	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 Report data for additional claims that have been billed	Ν		Ν		18.00
9.00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00

Heal th	Financial Systems HENRY COUNTY ME	MORIAL HOSPITAL		In Lie	u of Form CMS-	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0030 F	Period:	Worksheet S-	
				rom 01/01/2020 o 12/31/2020		enared
				1	7/30/2021 9:	<u>15 am</u>
			iption	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R	(	0	1.00 N	3.00 N	20.00
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's	N		N		21.00
	records? If yes, see instructions.					
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS I	HOSPI TALS)		1.00	
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprais	sais made duri	ng the cost	N	23.00
24.00	Were new leases and/or amendments to existing leases enter	red into durina	this cost rep	orting period?	Ν	24.00
	If yes, see instructions	g				
25.00	Have there been new capitalized leases entered into during	g the cost repo	rting period?	lfyes, see	N	25.00
o (   o o	instructions.					0, 00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during t instructions.	the cost report	ing period? IT	yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during th	ne cost reporti	na period?lf	ves. submit	Ν	27.00
	сору.			,, .		
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit e	entered into du	ring the cost	reporti ng	Y	28.00
20.00	period? If yes, see instructions.	a hand funda (D	abt Carul as Da	convo Fund)	Ν	29.00
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service Re	serve Fund)	N	29.00
30.00	Has existing debt been replaced prior to its scheduled mat		debt? If ves.	see	Ν	30.00
	instructions.	j -	<b>j</b> ,			
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see	N	31.00
	instructions.					-
32.00	Purchased Services Have changes or new agreements occurred in patient care se	arvicos furnish	ed through con	tractual	N	32.00
52.00	arrangements with suppliers of services? If yes, see instr		eu through con	ti actual	IN	52.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competit	ive bidding? If	N	33.00
	no, see instructions.			-		
0.4 00	Provi der-Based Physi ci ans				N/	
34.00	Are services furnished at the provider facility under an a If yes, see instructions.	arrangement wit	h provider-bas	ed physicians?	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended ex	kistina aareeme	nts with the p	rovi der-based	Ν	35.00
00100	physicians during the cost reporting period? If yes, see i		nto in the tho p	lorradi babba		
				Y/N	Date	
				1.00	2.00	
36 00	Home Office Costs Were home office costs claimed on the cost report?			N		36.00
36.00	If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	N		36.00
07.00	If yes, see instructions.	bi opul ou by the				07.00
38.00	If line 36 is yes, was the fiscal year end of the home of	ffice different	from that of	N		38.00
	the provider? If yes, enter in column 2 the fiscal year er					
39.00	If line 36 is yes, did the provider render services to oth	ner chain compo	nents? If yes,	N		39.00
40.00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lf ves see	N		40.00
40.00	instructions.		11 yes, see	i v		+0.00
		1.	00	2.	00	
41 00	Cost Report Preparer Contact Information			CMLTU		41.00
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	KYLE		SMI TH		41.00
	respectively.					
42.00	Enter the employer/company name of the cost report	BLUE & CO., LL	.C	1		42.00
	preparer.					
43.00	Enter the telephone number and email address of the cost	317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43.00
	report preparer in columns 1 and 2, respectively.			1		

Health Financial Systems HENRY	COUNTY MEN	MORIAL HOSPITAL	In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTI	ONNAI RE	Provider CCN: 15-0030	Period: From 01/01/2020	Worksheet S-2 Part II	
				Date/Time Pre 7/30/2021 9:1	pared: 5 am
		3.00			
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the title/po	osition	DI RECTOR			41.00
held by the cost report preparer in columns 1, 2	2, and 3,				
respecti vel y.					
42.00 Enter the employer/company name of the cost repo	ort				42.00
preparer.					
43.00 Enter the telephone number and email address of	the cost				43.00
report preparer in columns 1 and 2, respectively	y.				

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C		Period: From 01/01/2020 To 12/31/2020		pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00 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)	30.00	38	13, 90	0.00	0	1.00 2.00
3.00 4.00 5.00 6.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	3.00 4.00 5.00 6.00
7.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		38	13, 90	0. 00		7.00
8.00 9.00 10.00 11.00	INTENSI VE CARE UNI T CORONARY CARE UNI T BURN INTENSI VE CARE UNI T SURGI CAL INTENSI VE CARE UNI T	31.00	10	3, 66	0.00	0	8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER	43. 00	48	17, 56	58 O. OO	0 0 0	12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	101. 00 116. 00 30. 00	0		0	0	19.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00
25.00         26.00         26.01         26.25         27.00         28.00         29.00         30.00         31.00         32.00         32.00	RURAL HEALTH CLINIC RURAL HEALTH CLINIC II RURAL HEALTH CLINIC III 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	88. 00 88. 01 88. 02 89. 00	48 0		0	0 0 0 0	25.00 26.00 26.02 26.25 27.00 28.00 29.00 30.00 31.00 32.00
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01

	Financial Systems HE	NRY COUNTY MEMOF AL DATA	Provider CC		Period: From 01/01/2020 To 12/31/2020	u of Form CMS-: Worksheet S-3 Part I Date/Time Pre 7/30/2021 9:1	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2, 568	229	6, 41			1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	1, 765 0	1, 552 0				2.00 3.00
4.00 5.00 6.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	0 0	0 0 0		0		4.00 5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 568	229	6, 41	-		7.00
8.00 9.00 10.00 11.00 12.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	623	0	1, 39	1		8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00 17.00 18.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER	3, 191 0	0 229 0	55 8, 36		363. 20	13.00 14.00 15.00 16.00 17.00 18.00
<ol> <li>19.00</li> <li>20.00</li> <li>21.00</li> <li>22.00</li> <li>23.00</li> </ol>	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	4, 473	269	11, 96	.5 0.00	13. 20	19.0 20.0 21.0 22.0 23.0
24.00 24.10 25.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	O	0		0.00	5.64	
26.00 26.01 26.02 26.25 27.00	RURAL HEALTH CLINIC RURAL HEALTH CLINIC II RURAL HEALTH CLINIC III FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	5, 914 6, 181 248 0	2, 975 14, 902 347 0	20, 10 46, 65 1, 87	6 0.00	52.34 83.28 4.58 0.00 522.24	26.00 26.01 26.02 26.25
28.00 29.00 30.00 31.00 32.00	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions)	0	170 51				28.00 29.00 30.00 31.00 32.00
32. 01 33. 00	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0	51		0		32.0 32.0 33.0 33.0

OSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0030	Period: From 01/01/2020 To 12/31/2020		pare
		Full Time		Di se	charges		
		Equi val ents				<b>T</b>	
	Component	Nonpaid Workers 11.00	Title V 12.00	Title XVIII 13.00	Title XIX 14.00	Total All Patients 15.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00			2, 248	1.
. 00	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)			45		2,2.0	2.
00	HMO IPF Subprovider				0		3.
00	HMO IRF Subprovider				0		4
00	Hospital Adults & Peds. Swing Bed SNF						5
00	Hospital Adults & Peds. Swing Bed NF						6
00	Total Adults and Peds. (exclude observation beds) (see instructions)						7
00	INTENSIVE CARE UNIT						8
00	CORONARY CARE UNIT						9
. 00	BURN INTENSIVE CARE UNIT						10
. 00	SURGICAL INTENSIVE CARE UNIT						11
. 00	OTHER SPECIAL CARE (SPECIFY)						12
8.00	NURSERY						13
. 00	Total (see instructions)	0.00	0	84	18 53	2, 248	
. 00	CAH visits						15
. 00	SUBPROVIDER - IPF						16
. 00	SUBPROVIDER - IRF						17
. 00	SUBPROVI DER						18
. 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
. 00	HOME HEALTH AGENCY	0.00					22
. 00	AMBULATORY SURGICAL CENTER (D. P.)						23
. 00	HOSPI CE	0.00					24
. 10	HOSPICE (non-distinct part)						24
5.00	CMHC - CMHC						25
. 00	RURAL HEALTH CLINIC	0.00					26
. 01	RURAL HEALTH CLINIC II	0.00					26
o. 02	RURAL HEALTH CLINIC III	0.00					26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26
. 00	Total (sum of lines 14-26)	0.00					27
. 00	Observation Bed Days						28
. 00	Ambul ance Trips						29
. 00	Employee discount days (see instruction)						30
. 00	Employee discount days - IRF						31
2.00	Labor & delivery days (see instructions)						32
2. 01	Total ancillary labor & delivery room						32
	outpatient days (see instructions)						
3.00	LTCH non-covered days				0		33
. 01	LTCH site neutral days and discharges				0		33

SPI T	AL WAGE INDEX INFORMATION			Provider CC		eriod: rom 01/01/2020	Worksheet S-3 Part II	;
					T		Date/Time Pre	par
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	7/30/2021 9:1 Average	<u>5 a</u>
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Salaries (from Wkst.	(col.2 ± col. 3)	Salaries in col. 4	(col. 4 ÷ col. 5)	
		1.00		A-6)	-			
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES							1.
00	Total salaries (see instructions)	200.00	50, 486, 566	0	50, 486, 566	1, 287, 987. 00	39. 20	) 1
00	Non-physician anesthetist Part		0	0	0	0.00	0.00	
00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	
00	B Physician-Part A -		15,000	0	15,000	180.00	83. 33	3 4
	Administrative		10,000		10,000			
01 00	Physicians - Part A - Teaching Physician and Non		0 5, 153, 748	0	0 5, 153, 748	0.00 37,947.00	0. 00 135. 81	
	Physician-Part B							
00	Non-physician-Part B for hospital-based RHC and FQHC services		11, 947, 935	0	11, 947, 935	291, 603. 00	40.97	6
00	Interns & residents (in an	21.00	0	0	0	0.00	0.00	
01	approved program) Contracted interns and		0	0	0	0.00	0.00	
	residents (in an approved programs)							
00	Home office and/or related		0	0	0	0.00	0.00	8
00	organization personnel SNF	44.00	0	0	0	0. 00	0.00	) (
00	Excluded area salaries (see instructions)		3, 014, 134	419, 628	3, 433, 762	97, 890. 00	35.08	3 10
	OTHER WAGES & RELATED COSTS							
00	Contract Labor: Direct Patient Care		1, 937, 517	0	1, 937, 517	33, 537. 00	57.77	1
00	Contract Labor: Top Level		0	0	0	0.00	0.00	12
	management and other management and administrative							
~~	servi ces		171 000		171 000	1 11 ( 00	100 7(	
00	Contract Labor: Physician-Part A - Administrative		171, 000	0	171, 000	1, 416. 00	120. 76	
00	Home office and/or related organization salaries and		0	0	0	0.00	0.00	1
	wage-related costs							
01 02	Home office salaries		0	u u u u u u u u u u u u u u u u u u u	0	0.00 0.00	0.00 0.00	
02	Related organization salaries Home office: Physician Part A		0	, i i i i i i i i i i i i i i i i i i i	0	0.00	0.00	
00	- Administrative		0		0	0.00	0.00	1
00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	1
01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	1
02	Home office contract		0	0	0	0.00	0.00	1
	Physicians Part A - Teaching WAGE-RELATED COSTS							
00	Wage-related costs (core) (see		10, 799, 038	0	10, 799, 038			11
00	instructions) Wage-related costs (other)							18
	(see instructions)							
. 00 . 00	Excluded areas Non-physician anesthetist Part		561, 172 0	0	561, 172 0			10
.00	A Non-physician anesthetist Part		- -		0			2
	В		0 077		0 077			
00	Physician Part A - Administrative		2, 877	0	2, 877			22
01	Physician Part A - Teaching		0	0	717 2/2			22
00	Physician Part B Wage-related costs (RHC/FQHC)		717, 363 3, 501, 046		717, 363 3, 501, 046			23
00	Interns & residents (in an		0	0	0			2
50	approved program) Home office wage-related		0	0	0			2
51	(core) Related organization		0	0	0			2!
	wage-related (core)		0		0			
. 52	Home office: Physician Part A - Administrative -		0	0	0			25
	wage-related (core)							

	Financial Systems			ORIAL HOSPITAL		Period:	u of Form CMS-2	
HUSPII	AL WAGE INDEX INFORMATION			Provider C		From 01/01/2020 To 12/31/2020	Worksheet S-3 Part II Date/Time Prep 7/30/2021 9:1	pared
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.		(col. 4 ÷	
				(from Wkst. A-6)	3)	col. 4	col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		C		25.5
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI							
	Employee Benefits Department	4.00	284, 954		284, 95			
7.00	Administrative & General	5.00	6, 641, 642	0	6, 641, 64	2 144, 489. 00	45.97	27.
8.00	Administrative & General under		511, 814	0	511, 81	4 2, 628. 00	194.75	28.
	contract (see inst.)							
9.00	Maintenance & Repairs	6.00	0	0		0.00	0.00	
0.00	Operation of Plant	7.00	1, 495, 248	0	1, 495, 24		29. 32	
1.00	Laundry & Linen Service	8.00	0	0		0.00	0.00	
2.00	Housekeepi ng	9.00	572, 744				14.59	
3.00	Housekeeping under contract (see instructions)		93, 510	0	93, 51	1, 930. 00	48. 45	33.
4.00	Dietary	10.00	816, 113	-512, 210	303, 90	3 15, 261. 00	19. 91	34.
5.00	Dietary under contract (see instructions)		3, 165	0	3, 16	5 32.00	98. 91	35.
6.00	Cafeteria	11.00	0	291, 470	291, 47	0 14, 642. 00	19. 91	36.
7.00	Maintenance of Personnel	12.00	0	0	(	0.00	0.00	37.
8.00	Nursing Administration	13.00	2, 214, 220	25, 000	2, 239, 22	47, 689. 00	46.95	38.
9.00	Central Services and Supply	14.00	568, 369	0	568, 36	9 15, 244. 00	37.28	39.
0. 00	Pharmacy	15.00	0	0		0. 00	0.00	40.
1.00	Medi cal Records & Medi cal Records Li brary	16.00	703, 060	0	703, 06	29, 449. 00	23. 87	41.
12.00	Social Service	17.00	0	0		0.00	0.00	42.
43.00	Other General Service	18.00	0	0		0.00	0.00	43.

Heal th	Financial Systems	HE	NRY COUNTY MEN	IORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION			Provider C		Peri od:	Worksheet S-3	
						From 01/01/2020 To 12/31/2020		narod
						10 12/31/2020	7/30/2021 9:1	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
		1.00		A-6)		5.00		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY		-		-		
1.00	Net salaries (see		33, 993, 372	0	33, 993, 37	2 963, 027. 00	35.30	1.00
0.00	instructions)		0 014 404	440.400	0 400 74		25 00	0.00
2.00	Excluded area salaries (see		3, 014, 134	419, 628	3, 433, 76	2 97, 890. 00	35.08	2.00
2 00	instructions)		20 070 220	410 400	20 550 (1	0 0/5 127 00	25.22	2 00
3.00	Subtotal salaries (line 1 minus line 2)		30, 979, 238	-419, 628	30, 559, 61	0 865, 137. 00	35. 32	3.00
4.00	Subtotal other wages & related		2, 108, 517	0	2, 108, 51	7 34, 953. 00	60. 32	4.00
4.00	costs (see inst.)		2,100,517	0	2, 100, 51	7 54, 755.00	00.32	4.00
5.00	Subtotal wage-related costs		10, 801, 915	0	10, 801, 91	5 0.00	35.35	5.00
5.00	(see inst.)		10,001,713		10,001,71	0.00	55.55	5.00
6.00	Total (sum of lines 3 thru 5)		43, 889, 670	-419, 628	43, 470, 04	2 900, 090. 00	48.30	6.00
7.00	Total overhead cost (see		13, 904, 839					
	instructions)		,,,		,	000,221.00		
	· · · · · · · · · · · · · · · · · · ·			1	1	1	1	

	Financial Systems HENRY COUNTY MEMOR			u of Form CMS-2	
IOSPI	AL WAGE RELATED COSTS	Provider CCN: 15-0030	Period: From 01/01/2020	Worksheet S-3 Part IV	
			To 12/31/2020		pared:
				7/30/2021 9:1	5 am
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List RETIREMENT COST				
1.00	401K Employer Contributions			2 122 754	1.0
	Tax Sheltered Annuity (TSA) Employer Contribution			2, 132, 754 0	2.0
2.00 3.00	Nongualified Defined Benefit Plan Cost (see instructions)			0	3.0
1.00	Qualified Defined Benefit Plan Cost (see instructions)			0	
. 00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				4.0
5.00	401K/TSA Plan Administration fees			0	5.0
5.00 5.00	Legal /Accounting/Management Fees-Pension Plan			0	6.0
. 00 . 00	Employee Managed Care Program Administration Fees			0	7.0
. 00	HEALTH AND INSURANCE COST				1.0
. 00	Health Insurance (Purchased or Self Funded)			0	8.0
. 00	Health Insurance (Self Funded without a Third Party Administ	rator)		0	0.0
. 02	Heal th Insurance (Self Funded without a Third Party Administrat			8, 862, 924	
. 03	Heal th Insurance (Purchased)			0,002,724	
. 00	Prescription Drug Plan			0	
0.00	Dental, Hearing and Vision Plan			104, 124	
1.00	Life Insurance (If employee is owner or beneficiary)			202, 556	
2.00	Accident Insurance (If employee is owner or beneficiary)				12.0
3.00	Disability Insurance (If employee is owner or beneficiary)			617, 804	
	Long-Term Care Insurance (If employee is owner or beneficiar	-v)			14.0
5.00	'Workers' Compensation Insurance	<i>J</i> /		321, 682	
6.00	Retirement Health Care Cost (Only current year, not the extr	aordinary accrual requir	ed by FASB 106.	0	
	Non cumulative portion)			-	
	TAXES				
7.00	FICA-Employers Portion Only			3, 277, 023	17.0
8.00	Medicare Taxes - Employers Portion Only			0	18. C
9.00	Unemployment Insurance			42, 629	19.0
0.00	State or Federal Unemployment Taxes			0	20.0
	OTHER				
1. 00	Executive Deferred Compensation (Other Than Retirement Cost instructions))	Reported on lines 1 thro	ugh 4 above. (see	0	21.0
2.00	Day Care Cost and Allowances			0	22.0
	Tuition Reimbursement			20, 000	
	Total Wage Related cost (Sum of lines 1 -23)			15, 581, 496	
	Part B - Other than Core Related Cost				

Heal th	Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part V Date/Time Pre 7/30/2021 9:1	pared:
	Cost Center Description		Contract Labor	Benefit Cost	
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Ide				
1.00	Total facility's contract labor and bene	fit cost	1, 148, 742		
2.00	Hospi tal		1, 148, 742	15, 581, 496	
3.00	Subprovider - IPF				3.00
4.00	Subprovider - IRF				4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospital-Based SNF				8.00
9.00	Hospital-Based NF				9.00
10.00	Hospital-Based OLTC				10.00
11.00	Hospital-Based HHA		0	0	11.00
12.00	Separately Certified ASC				12.00
13.00	Hospi tal -Based Hospi ce		0	0	13.00
14.00	Hospital-Based Health Clinic RHC		0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1		0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2		0	0	14.02
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospi tal -Based-CMHC				16.00
17.00	Renal Dialysis				17.00
18.00	Other		0	0	18.00

	I Financial Systems HE HEALTH AGENCY STATISTICAL DATA	ENRY COUNTY MEMO	RIAL HOSPITAL Provider C		Peri od	l:	u of Form CMS-2 Worksheet S-4	
			Component	CCN: 15-7430	To 1	01/01/2020 2/31/2020	Date/Time Pre 7/30/2021 9:1	
						e Health ency I	PPS	
						1.(	00	
0.00	County							0.00
		Title V 1.00	<u>Title XVIII</u> 2.00	Title XIX 3.00		0ther 4.00	<u> </u>	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00		1				
1.00 2.00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0 0.00	0 250. 00		0 00	0 0. 00	0 0.00	1.00 2.00
2.00		0.00					me Equi val ent)	2.00
		Enter the number your normal		Staff	Co	ontract	Total	
		0		1.00		2.00	3.00	
3 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES		40.00		00	0.00	0.00	2 00
3. 00 4. 00 5. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	HOME HEALTH AGENCY CBSA CODES		40. 00	0. 2. 3. 43. 0. 29. 0. 4. 0. 0. 4. 0. 0. 0. 0. 0. 0. 0. 0. 17140	77 96 21 00 55 00 60 00 44 00 00 00 21 00	0.00 0.00	0.00 2.77 3.96 43.21 0.00 29.55 0.00 4.60 0.00 0.00 0.00 0.00 6.21 0.00 0.00	8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
20. 01 20. 02 20. 03	contains the first code).	5 11 5		26900 34620 99915				20. 01 20. 02 20. 03
		Full Epi Without W Outliers 1.00	sodes /ith Outliers 2.00	LUPA Epi sode		EP Only bisodes 4.00	Total (cols. 1-4) 5.00	
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Skilled Nursing Visit Charges Physical Therapy Visits Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visit Charges Speech Pathology Visits	1, 346 441, 134 1, 699 563, 401 172 55, 015 1, 679 0 0 340 53, 304 3, 562 0 1, 114, 533 315	189 62, 141 237 78, 551 157 50, 779 65 21, 443 0 207 32, 213 855 0 245, 127	10, 5 2, 3 12, 8	7 57 0 0 0 0 0 0 0 0 39 0	11 3, 729 6 2, 034 0 0 0 0 0 0 0 0 0 0 17 7 5, 763 2	1, 578 517, 507 1, 949 646, 343 329 105, 794 70 23, 122 0 0 547 85, 517 4, 473 0 1, 378, 283 340	22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00
37.00		1, 085	29 66		46	0	29 1, 197	37.00 38.00

Heal th	Financial Systems HE	ENRY COUNTY MEN	NORIAL HOSPITAL		In Li	eu of Form CMS-2	2552-10
	AL-BASED RHC/FQHC STATI STI CAL DATA			CN: 15-0030 F	Period:	Worksheet S-8	
			Component		From 01/01/2020 Fo 12/31/2020		
					RHC I	Cost	
					1	. 00	
	Clinic Address and Identification				1	. 00	
1.00	Street		1		2200 FOREST R		1.00
				ty 00	State 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County		NEW CASTLE	00		3.00 N 47362	2.00
			<u>,</u>				
0.00				- terrer		1.00	0.00
3.00	HOSPITAL-BASED FOHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for		Award	Date 0	3.00
					. 00	2.00	
	Source of Federal Funds			1			
4.00 5.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4.00 5.00
5.00 6.00	Health Services for the Homeless (Section 34						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of	other operatio	ns in column	N	0	10.00
		Sur	nday	Мог	nday	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00	CLINIC			08: 00	17:00	08: 00	11.00
12.00	Have you received an approval for an excepti	on to the prod	luctivity stand	ard?	1.00 Y	2.00	12.00
	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N	0	
					ler name	CCN number	
14 00	RHC/FQHC name, CCN number			1.	00	2.00	14.00
14.00		Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
				inty	_		
2.00	City, State, ZIP Code, County		4. HENRY	00			2.00
2.00	or cy, oraco, zri obao, obarry	Tuesday		esday	Thu	rsday	2.00
		to	from	to	from	to	
	Facility hours of operations (1)	6.00	7.00	8.00	9.00	10.00	
11.00		17:00	08: 00	17:00	08: 00	17:00	11.00
		•		•	•		•

Health Financial Systems H	IENRY COUNTY MEN	MORIAL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0030	Period: From 01/01/2020	Worksheet S-8	
		Component	CCN: 15-8520		Date/Time Pre 7/30/2021 9:1	
			-	RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	08: 00	17:00				11.00

Heal th	Financial Systems HE	NRY COUNTY MEN	NORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 15-0030 F	Period:	Worksheet S-8	
			Component		From 01/01/2020 To 12/31/2020		
					RHC II	Cost	
					1	. 00	-
	Clinic Address and Identification				I	. 00	
1.00	Street		1		152 WI TTENBRAI	KER AVE	1.00
				ty	State	ZIP Code	
2.00	City, State, ZIP Code, County		NEW CASTLE	00	2.00	3.00 V47362	2.00
2.00	Terty, State, Zir Code, County		NEW CASTEL	-		147302	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for			0	3.00
					Award 00	Date 2.00	
	Source of Federal Funds			1.	00	2.00	
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00 7.00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	U(d), PHS Act)					6.00 7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)				1		9.00
					1.00		
10.00	Does this facility operate as other than a h	osni tal -based	RHC or EOHC? E	nter "Y" for	1.00 N	2.00	10.00
10.00	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of	other operatio	ns in column			10.00
		Sur	nday	Mor	nday	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00				07: 30	19:00	07: 30	11.00
		L					
10.00					1.00	2.00	10.00
	Have you received an approval for an excepti- Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	Y N	0	12.00 13.00
				Provi d	er name	CCN number	
14.00				1.	00	2.00	14.00
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
				inty	_		
2.00	City, State, ZIP Code, County		4. HENRY	00			2.00
2.00	orty, State, Zri Gode, Godifty	Tuesday		esday	Thu	rsday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1) CLINIC	19: 00	07: 30	19:00	07: 30	19:00	11.00
11.00		17.00	07.30	117.00	07.30	117.00	1 11.00

Health Financial Systems	HENRY COUNTY MEN	NRY COUNTY MEMORIAL HOSPITAL				2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	AL-BASED RHC/FQHC STATISTICAL DATA			Period:	Worksheet S-8	
		Component	CCN: 15-8525	From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
			-	RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	07: 30	17:00				11.00

HOSPITAL-BASED RH0/FORC STATUSTICAL DATA         Provider CN: 15-0030 (Septem 1/2)/231/2020         Period 0/20/2020 From 0/20/2020         Period 0/20/2020 From 0/20/2020         Period 0/20/2020 From 0/20/2020         Period 0/20/2020	Heal th	Financial Systems HE	NRY COUNTY MEN	MORIAL HOSPITAL		In Lie	eu of Form CMS	-2552-10
Component CCN: 15-8556         To         12/31/2020         District Time Prepared: 73/30/2027           Init: Address and Identification         1.00         1.00         1.00           1.00         Street         1.00         1.00           2.00         Distret         1.00         1.00           3.00         IOSPITAL-BASED Foldes: County         EMBRINGE CLIV         1.00           3.00         IOSPITAL-BASED Foldes: ONLY. Designation - Inter "R" for rural or "U" for urban         0.00         0.00           4.00         Exerct on Foderal Funds         1.00         2.00         4.00         5.00           4.00         Edention and Control Social S					CN: 15-0030			8
Bit III         Cost           1.00         Street         1.00         1.00           2.00         City         State         71.00           2.00         City         State         71.00           3.00         HOSPITAL-BASED FORCS ONLY: Designation - Enter "R" for rural or "U" for urban         0         2.00           3.00         HOSPITAL-BASED FORCS ONLY: Designation - Enter "R" for rural or "U" for urban         0         2.00           3.00         HOSPITAL-BASED FORCS ONLY: Designation - Enter "R" for rural or "U" for urban         0         2.00           4.00         Community Health Center (Section 330(d), PIS Act)         1.00         2.00         4.00           5.00         Migrant Resh th Center (Section 330(d), PIS Act)         1.00         2.00         5.00           6.00         Control in column 1. If yes, indicate number of other operations in column 1. If yes, indicate number of other operations in column 1. If yes, indicate number of other operations in column 1. If yes, indicate number of other operations in column 1. If yes, indicate number of other operations in column 1. If yes, indicate number of other operations in column 1. If yes, indicate number of other operations in column 1. If yes, indicate number of other operations on column 1. If yes, indicate number of other operations in column 1. If yes, indicate number of other operations in column 1. If yes, indicate number of other operations in column 1. If yes, indicate number of other operations in column 1. If yes, indicate number t				Component			) Date/Time Pr	
Image: Street         1.00           Clinic Address and Identification           Clinic Address and Identifica								<u>15 am</u>
Clinic Address and Identification         It op         Alt E. MAIN ST.         1.00           1.00         Street         City         State         71P Code         71P Code           2.00         City, State, ZIP Code, County         CAMBRIDGE CITY         1.00         2.00         3.00           2.00         City, State, ZIP Code, County         CAMBRIDGE CITY         1.00         2.00         3.00           3.00         HOSPITAL-BASED FOHCS ONLY. Designation - Enter "R" for rural or "U" for orban         Data of the state of the sta							COST	
1.00       Street       415 F. MAIN ST.       1.00       2.00       21P Code       1.00       2.00       3.00       1.00       2.00       3.00       1.00       2.00       1.00       2.00       1.00       2.00       1.00       2.00       1.00       2.00       1.00       2.00       1.00       3.00       1.00       1.00       2.00       1.00       3.00       1.00       3.00       1.00       3.00       1.00       3.00       1.00       3.00       1.00       3.00       1.00       3.00       1.00       3.00       1.00       3.00       1.00       3.00       1.00       3.00       1.00       2.00       1.00       3.00       1.00       2.00       1.00       3.00       1.00       2.00       1.00       2.00       1.00       0.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>1.</td><td>00</td><td></td></t<>						1.	00	
City         State         ZIP Code           2.00         City, State, ZIP Code, County         CAMBRIGGE CITY         1.00         2.00         3.00           2.00         Incomparison         CAMBRIGGE CITY         1.00         1.00         2.00         3.00           3.00         HOSPITAL-BASED FORCE ONLY. Designation - Enter "R" for rural or "U" for urban         0         1.00         3.00           4.00         Community Health Center (Section 330(0), PHS Act)         0         0         2.00         5.00         5.00         5.00         5.00         6.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td></t<>							-	
1.00         2.00         CITy, State, ZIP Code, County         DAMBRI DGE CITY         IN/7327         2.00           3.00         HOSPI TAL-BASED FORCE ONLY: Designation - Enter "R" for rural or "U" for urban         0         3.00         0<	1.00	Street		Ci	+1/			1.00
Summer         Summer         Summer         Summer         Image of the summer								
3.00         HOSPITAL-BASED FORCS ONLY: Designation - Enter "R" for rural or "U" for urban         0         0.00	2.00	City, State, ZIP Code, County						2.00
3.00         HOSPITAL-BASED FORCS ONLY: Designation - Enter "R" for rural or "U" for urban         0         0.00								
Source of Federal Funds         Grant Award         Date           1.00         2.00         1.00         2.00           4.00         Community Health Center (Section 320(d), PHS Act)         4.00           5.00         Migrant Health Center (Section 320(d), PHS Act)         4.00           6.00         Have Inthe Generes (Section 340(d), PHS Act)         6.00           7.00         Appalachian Regional Commission         6.00           0.00         OTHER (SPECIFY)         1.00         2.00           10.00         Dest hits facility operate as other than a hospital-based RIC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating         1.00         2.00           10.00         Dest hits facility hours of operations (1)         1.00         2.00         10.00         10.00         10.00         10.00           11.00         Cillink         1.00         2.00         10.00         11.00         10.00         11.00         10.00         10.00         10.00         12.00           12.00         Have you received an approval for an exception to the productivity standard?         Y         0         12.00           13.00         Is this a consol dated cost report as defined in CMs Pub. 100-04, chapter 9, secti	2 00	HOSPITAL BASED FOHCE ONLY: Designation Ent	or "P" for rur	al or "II" for	urban			2 00
1.00         2.00           Source of Federal Funds         1.00         2.00           4.00         Community Health Center (Section 330(d), PHS Act)         5.00         5.00           0.00         Health Services for the Homeless (Section 340(d), PHS Act)         5.00         5.00           0.00         Health Services for the Homeless (Section 340(d), PHS Act)         5.00         7.00           0.00         THER (SPECIFY)         1.00         2.00         7.00           10.00         Dees this facility operate as other than a hospital-based RHC or F0HC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in colum phours.)         N         0         10.00           2. (Enter in subscripts of line 11 the type of other operations in colum phours.)         Tuesday         Tuesday         1.00         2.00         11.00           1.00         2.00         3.00         4.00         5.00         11.00         1.00         2.00         11.00           1.00         2.00         3.00         4.00         5.00         11.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00	3.00	THOSE TRE-DASED TORCS ONET. Designation - Ent				Award		3.00
4.00         Community Health Center (Section 330(d), PHS Act)         4.00           5.00         Migrant Health Center (Section 330(d), PHS Act)         5.00           6.00         Health Services for the Homeless (Section 340(d), PHS Act)         6.00           7.00         Appalachian Regional Commission         7.00           8.00         Look-Alikes         9.00           9.00         DHER (SPECIFY)         1.00         2.00           10.00         Dees this facility operate as other than a hospital-based RHC or FOHC? Enter "V" for N         0         10.00           2. (Enter in subscripts of line 11 the type of other operations in column 1. If yes, indicate number of form to from to from to from 1.00 or 2.00         10.00         2.00         11.00         2.00         11.00         12.00								
5.00         Wigrant Health Center (Section 329(d), PHS Act)         5.00         7.00         5.00         7.00         8.00         9.00         10.00         2.00         11.00         2.00         11.00         <					T		T	
6.00         Health Services for the Homeless (Section 340(d), PHS Act)         6.00         6.00         6.00         6.00         8.00         5.00         8.00         5.00         8.00         7.00         8.00         9.00         10.00         2.00         10.00         9.00         10.00         10.00         10.00         10.00         10.00         11.00         12.00         11.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00								
7.00       Appal achi an Regional Commission       7.00       0.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
9.00       OTHER (SPECIFY)       9.00         10.00       Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operations(s) and the operating hours.)       N       0       10.00         2. (Enter in subscripts of line 11 the type of other operations(s) and the operating hours.)       Monday       Tuesday       0       10.00         Sunday       Monday       Tuesday       Tuesday       0       10.00         Inter "Y" for work of operations (1)         11.00       CLINIC       08:00       19:00       08:00       11.00         10.00       Record of the operation to the productivity standard?       Y       0       13:00         10.00       Have you received an approval for an exception to the productivity standard?       Y       12:00       13:00       13:00         10.00       RecON number       1.00       2:00       13:00         10:00       RecON number       10:00       2:00       13:00         10:00       RecON number       14:00         10:00       RecON number       14:00         10:00       2:00       3:00								
10.00     Does this facility operate as other than a hospital-based RHC or F0HC? Enter "Y" for vessor "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operations) and the operating hours.)     N     0     10.00       2. (Enter in subscripts of line 11 the type of other operations) and the operations invors.)     Sunday     Monday     Tuesday       from     to     from     to     from     0     10.00       1.00     2.00     3.00     4.00     5.00     11.00       11.00     CLINIC     08:00     19:00     08:00     11.00       12.00     Have you received an approval for an exception to the productivity standard?     Y     N     0     12.00       13.00     RRC/FGHC name, CCN number     1.00     2.00     3.00     4.00     5.00       14.00     RRC/FGHC name, CCN number     1.00     2.00     3.00     4.00     5.00       14.00     RRC/FGHC name, CCN number     1.00     2.00     3.00     4.00     5.00       15.00     Have you provided all or substantially all Muthers of providers for titles v, XVIII, and XIX, as applicable. Enter in column 5.2, 3 and A the number of total visits performed by Intern & Residents for titles v, XVIII, and XIX, as applicable. Enter in column 5.0     10.00     10.00     10.00       2.00     Clity. State, ZIP Code, County	8.00							
ID.00         Does this facility operate as other than a hospital-based RHC or FoHC? Enter "Y" for pours.)         N         0         10.00           2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)         Monday         Tuesday         0         10.00           2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)         Monday         Tuesday         0         10.00           Eacility hours of operations (1)         1.00         2.00         3.00         4.00         5.00         11.00           12.00         Have you received an approval for an exception to the productivity standard?         Y         0         12.00         12.00         14 box of from to column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.         N         0         13.00           14.00         RHC/FOHC name, CCN number         1.00         2.00         3.00         4.00         5.00           15.00         BME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2, 3 and d the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 3, 2, and d XIX, as applicable. Enter in column 3, the number of the number of total Visits for this provider.         2.00         15.00           2.00         City, State, ZIP Code, County         HENRY         4.00	9.00	OTHER (SPECI FY)						9.00
10.00         Does this facility operate as other than a hospital-based RHC or FOHC? Enter "Y" for pours.)         N         0         10.00           2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)         Sunday         Monday         Tuesday           from         to         from         to         from         to         from           10.00         2.00         3.00         4.00         5.00         11.00           Eacility hours of operations (1)         1.00         2.00         3.00         4.00         5.00           11.00         Clinic         0         10.00         2.00         1.00         2.00         1.00         2.00           12.00         Have you received an approval for an exception to the productivity standard?         Y         1.00         2.00         12.00           13.00         30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number's below.         1.00         2.00         14.00         14.00         14.00         14.00         14.00         14.00         14.00         14.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00						1.00	2 00	
yes or "N" for no'in column 1. If yes, indicate number of other operations in column 1. If yes, indicate number of other operations of the operations of the operation (s) and (s)	10.00	Does this facility operate as other than a h	ospi tal -based	RHC or FQHC? E	nter "Y" for			0 10.00
Indurs.)         Sunday         Monday         Tuesday           from         to         from         to         from           1.00         2.00         3.00         4.00         5.00           11.00         CLINIC         08:00         19:00         08:00         11.00           12.00         Have you received an approval for an exception to the productivity standard?         Y         12.00         13.00         12.00         13.00         12.00         13.00         13.00         13.00         13.00         13.00         13.00         14.00         2.00         14.00         13.00         13.00         13.00         13.00         14.00         14.00         14.00         14.00         14.00         14.00         14.00         5.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         10.00         2.00         14.00         14.00         14.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.		yes or "N" for no in column 1. If yes, indic	ate number of	other operatio	ns in column			
Sunday         Monday         Tuesday           from         to         from         to         from         to         from           1.00         2.00         3.00         4.00         5.00         11.00           1.00         CLINIC         08:00         19:00         08:00         11.00           1.00         Sthis a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section         N         0         13.00           13:00         Stenter "V" for yes or "N" for no in column 1. If yes, enter in colum 2 the number of providers included in this report. List the names of all providers and numbers below.         N         0         13.00           14.00         RHC/FOHC name, CCN number         1.00         2.00         14.00         14.00         2.00         14.00           15.00         Have you provided all or substantially all or substantially all for a column 1. If yes, enter in column 2, 3 and 4 the number of program visits performed by Intern & Residents for this provider.         14.00         5.00         15.00           16.00         Its yes anter in column 5, the number of total visits for this provider.         1.00         2.00         15.00           17.00         County         Its yes anglicable. Enter in column 5, the number of total visits for this provider.         14.00         15.00         15.00		1 51	f other operat	ion(s) and the	operating			
from         to         from         to         from           Facility hours of operations (1)         1.00         2.00         3.00         4.00         5.00           11.00         CLINIC         08:00         19:00         08:00         11.00           12.00         Have you received an approval for an exception to the productivity standard?         Y         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         14.00         2.00         14.00         14.00         14.00         14.00         14.00         14.00         14.00         5.00         15.00         15.00         4.00         5.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         2.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.0		nour's. )	Sur	ndav	Мо	ndav	Tuesday	
Facility hours of operations (1)         11.00       Clivic         (2.00       Have you received an approval for an exception to the productivity standard?       Y       12.00         12.00       1s this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N       V       V       12.00         13.00       1s this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N       V       0       13.00         13.00       1s this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N       V       0       13.00         13.00       1s this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N       V       0       13.00         13.00       1s this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N       V       0       13.00         13.00       1s this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N       0       13.00         14.00       REC/FOHC name, CCN number       1.00       2.00       14.00       14.00         15.00       Have you provided all or substantially all gME cost? Enter 'V' for yes or 'N' for no in columns 2, 3 and 4 the number of program wisits performed by lintern & Residents for tiles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				1 2				
11.00       CLINIC       08:00       19:00       08:00       11.00         12.00       Have you received an approval for an exception to the productivity standard?       Y       12.00       12.00         13.00       Is this a consolidated cost report as defined in CKP pub. 100-04, chapter 9, section 30.87 Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.       N       0       13.00         14.00       RHC/FQHC name, CCN number       1.00       2.00       14.00         14.00       RHC/FQHC name, CCN number       14.00       2.00       14.00         15.00       Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 2, 3 and 4 the number of program visits performed by Inter & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5, 2, 3 and 4 the number of total visits for this provider. (see instructions)       Image: County total visits for this provider. (see instructions)       2.00       15.00         2.00       City, State, ZIP Code, County       HENRY       2.00       2.00       10.00         2.00       City, State, ZIP Code, County       HENRY       2.00       2.00       10.00         Image: County total visits for this provider. (see instructions)       Image: County total visits for this provider. (see instructions)       2.00       10.00       2.00 </td <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td>			1.00	2.00	3.00	4.00	5.00	
12.00     Have you received an approval for an exception to the productivity standard?     1.00     2.00       13.00     Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.     N     0     13.00       14.00     RHC/FOHC name, CCN number     14.00     2.00     14.00       15.00     Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in columns 5 the number of total visits for this provider. (see instructions)     County     15.00       County     4.00     4.00     4.00     2.00       12.00     City, State, ZIP Code, County     Tuesday     Wednesday     Thursday       Tuesday     Wednesday     Thursday     2.00       Facility hours of operations (1)     5.00     10.00     0	11 00			-	00.00	10.00	00.00	11 00
12.00       Have you received an approval for an exception to the productivity standard?       Y       12.00         13.00       Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section number of providers included in this report. List the names of all providers and numbers below.       N       0       13.00         14.00       RHC/FOHC name, CCN number       1.00       2.00       14.00         14.00       RHC/FOHC name, CCN number       Y/N       V       XVIII       XIX       Total Visits         15.00       Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for this provider. (see instructions)       15.00       Soot       15.00       15.00       15.00       2.00       15.00       2.00       15.00       5.00       15.00         KX x as applicable. Enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for this provider. (see instructions)       V       V       VIII       XI x       15.00         County       4.00       Enter in column 5 the number of total visits for this provider. (see instructions)       2.00       2.00       2.00         It uses any licable. Enter in column 5 the number of total visits for this provider. (see instructions)       Y       Y       Y       Y       Y       Y	11.00				08:00	19:00	08:00	11.00
12.00       Have you received an approval for an exception to the productivity standard?       Y       12.00         13.00       Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section number of providers included in this report. List the names of all providers and numbers below.       N       0       13.00         Provider name       CCN number         14.00       RHC/FOHC name, CCN number       14.00       2.00       14.00         15.00       Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in columns 2, 3 and 4 the number of total visits for this provider. (see instructions)       Image: County defined by Intern & Residents for this provider. (see instructions)       2.00       15.00         County defined in County define						1.00	2.00	
30. 8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.       Provider name       CCN number         14.00       RHC/FOHC name, CCN number       14.00       2.00       14.00         14.00       RHC/FOHC name, CCN number       14.00       2.00       14.00         15.00       Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)       County       15.00         2.00       City, State, ZIP Code, County       HENRY       2.00       2.00         Tuesday         Tuesday       Thursday         Tuesday         Tuesday         Tuesday         Tuesday         The first hours of operations (1)						Y		
number of providers included in this report. List the names of all providers and numbers below.     Provider name     CCN number       14.00     REC/FQHC name, CCN number     14.00       14.00     XVN     V     XVIII     XIX     Total Visits       14.00     REC/FQHC name, CCN number     14.00       14.00     XVN     V     XVIII     XIX     Total Visits       14.00     2.00     3.00     4.00       Substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)     County       Tuesday     Tuesday     Thursday       Tuesday     Thursday       Tuesday     Total visits       Tuesday     Thursday       Tuesday     Thursday       Tuesday     Thursday       Tuesday     Total visits	13.00					N	(	0 13.00
numbers below.         Provider name         CCN number           14.00         RHC/FOHC name, CCN number         1.00         2.00           14.00         RHC/FOHC name, CCN number         14.00           15.00         Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)         County         15.00           2.00         City, State, ZIP Code, County         HENRY         2.00         2.00           100         Tuesday         Wednesday         Thursday           100         Facility hours of operations (1)         HENRY         2.00								
1.00         2.00           14.00         RHC/FQHC name, CCN number         14.00           14.00         Y/N         V         XVIII         XIX         Total Visits           15.00         Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for tiles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)         County         15.00           2.00         City, State, ZIP Code, County         HENRY         2.00         2.00         10.00           2.00         City, State, ZIP Code, County         HENRY         2.00         2.00         10.00           4 to from         to         from         to         from         to         from         2.00								
14.00       RHC/FOHC name, CCN number       14.00         Y/N       V         XVN       V       XVIII       XIX       Total Visits         15.00       Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)       15.00       15.00         2.00       County       4.00       2.00       2.00       2.00         2.00       City, State, ZIP Code, County       HENRY       2.00       2.00         Facility hours of operations (1)       Tuesday       Wednesday       Thursday					-			
Y/N         V         XVIII         XIX         Total Visits           15.00         Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)         Image: County transform to the set of the	14.00				1	. 00	2.00	14.00
Image: Note of the second se	14.00		Y/N	V	XVIII	XIX	Total Visits	
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) <ul> <li>County</li> <li>County</li> <li>Question of the county</li> <li>County</li> <li>County</li></ul>				-				
column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)       VIIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)       County       V         2.00       City, State, ZIP Code, County       HENRY       2.00         2.00       City, State, ZIP Code, County       HENRY       2.00         Tuesday       Thursday       Thursday         to       from       to         Facility hours of operations (1)       Facility hours of operations (1)       V	15.00							15.00
4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)     Image: County image								
Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)     County       2.00     City, State, ZIP Code, County     4.00       2.00     City, State, ZIP Code, County     2.00       Tuesday     Wednesday     Thursday       To     from     to       6.00     7.00     8.00     9.00								
XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)       Image: County 4.00         2.00       City, State, ZIP Code, County       HENRY       2.00         2.00       City, State, ZIP Code, County       HENRY       2.00         Facility hours of operations (1)								
(see instructions)         County           2.00         City, State, ZIP Code, County         HENRY         2.00           Tuesday         Tuesday         Thursday         2.00           Tuesday         Kennesday         Thursday         2.00           Facility hours of operations (1)         Facility hours of operati		XIX, as applicable. Enter in column 5 the						
County         4.00         2.00         City, State, ZIP Code, County         HENRY         2.00           Tuesday         Wednesday         Thursday         2.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
4.00           4.00           2.00 City, State, ZIP Code, County         HENRY         2.00           Tuesday         Wednesday         Thursday           to         from         to           Facility hours of operations (1)				Col	untv		I	
Tuesday         Wednesday         Thursday           to         from         to         from         to           6.00         7.00         8.00         9.00         10.00						-		
to         from         to         from         to           6.00         7.00         8.00         9.00         10.00	2.00	City, State, ZIP Code, County						2.00
6.00         7.00         8.00         9.00         10.00           Facility hours of operations (1)							1 2	
Facility hours of operations (1)								
		Facility hours of operations (1)	0.00	,	0.00	7.00		
	11.00	CLINIC	19: 00	08: 00	19:00	08: 00	19:00	11.00

Health Financial Systems	MORIAL HOSPITAL	RIAL HOSPITAL In Lieu of Form CM				
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	C STATISTICAL DATA			Period:	Worksheet S-8	
		Component	CCN: 15-8556	From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
				RHC III	Cost	
	Fri	i day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	08: 00	19: 00	08: 00	12:00		11.00

HOSPI -	FAL-BASED HOSPICE IDENTIFICATION	DATA		Provider CC Hospice CC	CN: 15-0030 N: 15-1564	Period: From 01/01/2020 To 12/31/2020		GH IV pared:
						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	Facility 3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR CO					5.00	0.00	
1.00 2.00 3.00 4.00 5.00	Hospice Continuous Home Care Hospice Routine Home Care Hospice Inpatient Respite Care Hospice General Inpatient Care Total Hospice Days							1.00 2.00 3.00 4.00 5.00
	Part II - CENSUS DATA FOR COST	REPORTING PER	ODS BEGINNING	BEFORE OCTOBER	R 1, 2015			
6.00 7.00	Number of patients receiving hospice care Total number of unduplicated Continuous Care hours billable							6. 00 7. 00
3. 00	to Medicare Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00
OTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
				1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERIODS BEGI	NNING ON OR AFT	TER OCTOBER 1	· · · · · · · · · · · · · · · · · · ·		
10.00 11.00 12.00	Hospice Continuous Home Care Hospice Routine Home Care Hospice Inpatient Respite Care			0 3, 497 24		0 0 0 1, 028 0 0		10.00 11.00 12.00
13.00	Hospice General Inpatient Care Total Hospice Days			21		0 0 0 1,028	21	13.00 14.00
	PART IV - CONTRACTED STATISTIC	AL DATA FOR COS	ST REPORTING P		IG ON OR AFTE			11.00
15.00				0		0 0	-	15.00
13.00								

Heal th	Financial Systems HENRY COUNTY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
H0SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CO	CN: 15-0030	Peri od:	Worksheet S-1	0
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	ivided by li	ne 202 colum	n 8)	0. 322873	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				5, 803, 068	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplement If line 4 is no, then enter DSH and/or supplemental payments to			ai d?	Y O	4.00 5.00
5.00 6.00	Medicaid charges	IT OIL MEULCAL	u		42, 451, 139	6.00
7.00	Medicaid cost (line 1 times line 6)				13, 706, 327	7.00
8.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	(line 7 mir	nus sum of li	nes 2 and 5; if	7, 903, 259	8.00
	Children's Health Insurance Program (CHIP) (see instructions 1	For each lir	ne)		I	
9.00	Net revenue from stand-alone CHIP				0	9.00
	Stand-alone CHIP charges				0	10.00
	Stand-alone CHIP cost (line 1 times line 10)	(1)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP enter zero)	(IINE II MI	nus line 9;	IT < Zero then	0	12.00
	Other state or local government indigent care program (see ins	structions f	for each line	)	I	
13.00	Net revenue from state or local indigent care program (Not ind				0	13.00
14.00	Charges for patients covered under state or local indigent can	re program (	(Not included	in lines 6 or	0	14.00
	10)					
	State or local indigent care program cost (line 1 times line			45	0	15.00
16.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero)	ndigent care	e program (II	ne 15 minus line	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, Ch	HP and stat	te/local indi	gent care progra	ams (see	
	instructions for each line)			5		
	Private grants, donations, or endowment income restricted to t				0	17.00
	Government grants, appropriations or transfers for support of				0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loca 8, 12 and 16)	ar indigent	care program	s (sum of fines	7, 903, 259	19.00
			Uni nsured	Insured	Total (col. 1	
			patients 1.00	patients 2.00	+ col. 2) 3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire fa	acility	672, 48	522, 065	1, 194, 549	20.00
	(see instructions)	5				
21.00	Cost of patients approved for charity care and uninsured disco instructions)	ounts (see	217, 12	27 522, 065	739, 192	21.00
22.00	Payments received from patients for amounts previously written charity care	n off as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		217, 12	27 522, 065	739, 192	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patie		yond a length	of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond		t care progra	m's length of	0	25.00
24 00	stay limit		<b>`</b>		( 570 10(	24 00
26.00 27.00	Total bad debt expense for the entire hospital complex (see in Medicare reimbursable bad debts for the entire hospital complete	,			6, 570, 196 159, 957	26.00 27.00
	Medicare allowable bad debts for the entire hospital complex				246, 087	27.00
	Non-Medicare bad debt expense (see instructions)	(200 1101140			6, 324, 109	
	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	xpense (see	instructions	)	2, 128, 014	
	Cost of uncompensated care (line 23 column 3 plus line 29)	•			2, 867, 206	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	line 30)			10, 770, 465	31.00

	Financial Systems HE SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	ENRY COUNTY MEMO OF EXPENSES	RIAL HOSPITAL Provider CO		eri od:	u of Form CMS-2 Worksheet A	2552-10
				F	rom 01/01/2020 o 12/31/2020		pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Recl assi fi cat i ons (See A-6)	7/30/2021 9:1 Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		5, 353, 429	5, 353, 429	-92, 605	5, 260, 824	1.00
2.00	00200 NEW CAP REL COSTS-BEDG & FIXT		5, 555, 429 0	0, 303, 429 0	-92, 803	341,695	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	284, 954	10, 895, 343	11, 180, 297	2, 327, 451	13, 507, 748	4.00
5.00	00500 ADMINI STRATI VE & GENERAL	6, 641, 642	9, 490, 759	16, 132, 401	-2, 500	16, 129, 901	5.00
7.00	00700 OPERATION OF PLANT	1, 495, 248	1, 697, 067	3, 192, 315	0	3, 192, 315	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	444, 824	444, 824	0	444, 824	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	572, 744 816, 113	347, 061 511, 684	919, 805 1, 327, 797	-40, 202 -828, 715	879, 603 499, 082	9.00 10.00
11.00	01100 CAFETERI A	010, 113	0 0	1, 327, 797	474, 215	474, 215	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 214, 220	216, 103	2, 430, 323	24, 281	2, 454, 604	
14.00	01400 CENTRAL SERVICES & SUPPLY	568, 369	448, 672	1, 017, 041	0	1, 017, 041	14.00
15.00	01500 PHARMACY	0	5, 203, 351	5, 203, 351	-197, 510	5,005,841	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	703, 060	163, 181	866, 241	-694	865, 547	16.00
30.00	03000 ADULTS & PEDIATRICS	6, 105, 420	2, 138, 692	8, 244, 112	-820, 755	7, 423, 357	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 431, 380	354, 813	1, 786, 193	0	1, 786, 193	•
43.00	04300 NURSERY	0	0	0	592, 978	592, 978	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	5 007 000	0.000.70/	11.010.101	0 000 770	( 501 045	50.00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	5, 027, 388	9, 882, 736 0	14, 910, 124 0	-8, 328, 779 215, 339	6, 581, 345 215, 339	50.00 52.00
52.00	05400 RADI OLOGY-DI AGNOSTI C	1, 760, 606	930, 932	2, 691, 538	-283, 577	2, 407, 961	54.00
57.00	05700 CT SCAN	184, 384	867, 494	1, 051, 878	0	1, 051, 878	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	106, 119	499, 000	605, 119	-22, 000	583, 119	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	1, 965, 601	3, 172, 119	5, 137, 720 0	0	5, 137, 720 0	60.00 60.01
65.00	06500 RESPIRATORY THERAPY	811, 310	304, 024	1, 115, 334	-1, 682	1, 113, 652	65.00
66.00	06600 PHYSI CAL THERAPY	1, 546, 663	968, 799	2, 515, 462	-558	2, 514, 904	66.00
67.00	06700 OCCUPATI ONAL THERAPY	222, 058	16, 264	238, 322	0	238, 322	67.00
68.00	06800 SPEECH PATHOLOGY	88, 753	6, 214	94, 967	0	94, 967	68.00
69.00	06900 ELECTROCARDI OLOGY	176, 849	178, 095	354, 944	0	354, 944	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	-417, 967	-417, 967 0	2, 558, 145 5, 480, 052	2, 140, 178 5, 480, 052	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0,400,032	0,400,002	73.00
76.00	03950 CARDI AC REHAB	110, 362	12, 802	123, 164	0	123, 164	76.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	4, 084, 724 7, 570, 783	1, 832, 587 3, 618, 075	5, 917, 311 11, 188, 858	-779, 600 -940, 034	5, 137, 711 10, 248, 824	88.00 88.01
88.02	08802 RURAL HEALTH CLINIC III	501, 305	403, 110	904, 415	-349, 889	554, 526	88.02
91.00	09100 EMERGENCY	2, 482, 377	1,077,420	3, 559, 797	0	3, 559, 797	91.00
92.00							92.00
101 00	OTHER REIMBURSABLE COST CENTERS	1 152 054	242,200	1 414 252	10 001	1 402 021	101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 153, 854	262, 398	1, 416, 252	-13, 221	1, 403, 031	101.00
113.00	11300 I NTEREST EXPENSE		0	0	0	0	113.00
	11400 UTILIZATION REVIEW-SNF	0	0	0	0		114.00
	11600 HOSPI CE	513, 525	452, 582		-6, 026	960, 081	
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	49, 139, 811	61, 331, 663	110, 471, 474	-694, 191	109, 777, 283	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 165, 908	602, 101	1, 768, 009	-85, 748	1, 682, 261	
	07950 HOSPI TALI ST	0	0	0	0		194.00
	07951 RENTAL	0	0	0	92, 605	92,605	
	07955 OTHER NONREIMBURSABLE COSTS 07956 DR AFZAL	0	206, 569 4, 402	206, 569 4, 402	0	206, 569	194.05 194.06
	07950 DK AFZAL 07957 PHI LLI PS HALL	0	4,402	4,402	0		194.08
	07958 OB DRS	Ő	0	0	0		194.08
	07959 THE WATERS	0	0	0	394, 702	394, 702	194.09
	07960 CAMBRI DGE CI TY	0	0	0	294, 632	294, 632	
	07961 WELL BEING 207962 ACTIVATE HEALTH EMPLOYER CLINIC	0	568 64, 502	568 64, 502	0	568 64, 502	194.11
	07962 ACTIVATE HEALTH EMPLOYER CLINIC	0	04, 302 N	04, 302 N	0		194.12
	07964 HENRY COUNTY RADIOLOGY	180, 847	1, 441, 323	1, 622, 170	-2,000	1, 620, 170	•
	07965 HENRY COUNTY ANESTHESI OLOGY	0	0	0	0		194. 15
	07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0 50 404 544	0	114 127 404	0	0 114, 137, 694	194.16
200.00	TOTAL (SUM OF LINES 118 through 199)	50, 486, 566	63, 651, 128	114, 137, 694	U U	114, 137, 094	l∠00. 00

OLA00	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provider CCN: 15		sheet A
					/Time Prepare /2021 9:15 an
	Cost Center Description	Adjustments	Net Expenses	17307	2021 9.15 8
		(See A-8)	For		
		6.00	Allocation 7.00		
C	ENERAL SERVICE COST CENTERS	6.00	7.00		
	DO100 NEW CAP REL COSTS-BLDG & FIXT	-127, 760	5, 133, 064		1.
	DO200 NEW CAP REL COSTS-MVBLE EQUIP	0			2
	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 796, 257	16, 304, 005		4
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	-2, 100, 207	14, 029, 694		5
	00800 LAUNDRY & LINEN SERVICE	0	3, 192, 315 444, 824		8
	00900 HOUSEKEEPI NG	6, 265			9
	01000 DI ETARY	-48, 313			10
	01100 CAFETERIA	-254, 516			11
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	89, 978 0			13
	D1500 PHARMACY	-875, 677	1, 017, 041 4, 130, 164		14
	01600 MEDICAL RECORDS & LIBRARY	-6, 429			16
	NPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS	-3, 080, 397	4, 342, 960		30
	03100 INTENSIVE CARE UNIT	0			31
	04300 NURSERY NCILLARY SERVICE COST CENTERS	0	592, 978		43
	D5000 OPERATING ROOM	-2, 946, 434	3, 634, 911		50
. 00 0	D5200 DELIVERY ROOM & LABOR ROOM	0	215, 339		52
	05400 RADI OLOGY-DI AGNOSTI C	-1,043			54
	05700 CT SCAN	-553, 509			57
	D5800 MAGNETIC RESONANCE IMAGING (MRI) D5900 CARDIAC CATHETERIZATION	-294, 022	289, 097		58
	06000 LABORATORY	-30, 162	5, 107, 558		60
	06001 BLOOD LABORATORY	0	0		60
	06500 RESPI RATORY THERAPY	-1, 630			65
	06600 PHYSI CAL THERAPY	-678, 916	1, 835, 988		66
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	238, 322 94, 967		67 68
	06900 ELECTROCARDI OLOGY	0	354, 944		69
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 140, 178		71
	07200 IMPL. DEV. CHARGED TO PATIENT	0	5, 480, 052		72
	07300 DRUGS CHARGED TO PATIENTS	0	100 514		73
	03950 CARDIAC REHAB DUTPATIENT SERVICE COST CENTERS	350	123, 514		76
	08800 RURAL HEALTH CLINIC	-446, 097	4, 691, 614		88
	08801 RURAL HEALTH CLINIC II	-2, 305, 362	7, 943, 462		88
	08802 RURAL HEALTH CLINIC III	-120, 917			88
	09100 EMERGENCY	-46, 534	3, 513, 263		91
	09200 OBSERVATION BEDS (NON-DISTINCT PART) DTHER REIMBURSABLE COST CENTERS				92
	10100 HOME HEALTH AGENCY	-16, 268	1, 386, 763		101
S	SPECIAL PURPOSE COST CENTERS				
	1300 INTEREST EXPENSE	0	0		113
	11400 UTI LI ZATI ON REVI EW-SNF 11600 HOSPI CE	15 472	0 944, 408		114 116
8.001 8.00	SUBTOTALS (SUM OF LINES 1 through 117)	-15, 673 -11, 057, 016			118
	IONREI MBURSABLE COST CENTERS	11,007,010	70,720,207		
D. 00 1	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-		190
	19200 PHYSI CLANS' PRI VATE OFFI CES	-45, 822	1, 636, 439		192
	07950 HOSPI TALI ST 07951 RENTAL	0	0 92, 605		194 194
	07951 RENTAL 07955 OTHER NONREI MBURSABLE COSTS		92, 605 206, 569		194
	07956 DR AFZAL	0	4, 402		194
1. 07 C	07957 PHI LLI PS HALL	0	0		194
	07958 OB DRS	0	0		194
	07959 THE WATERS	0	394, 702		194
	07960 CAMBRI DGE CI TY 07961 WELL BEI NG	0	294, 632 568		194 194
	07961 WELL BEING 07962 ACTIVATE HEALTH EMPLOYER CLINIC		64, 502		194
	07963 NEW CASTLE PEDIATRICS	0	04, 302		194
4.130		0	1, 620, 170		194
4.14 C	07964 HENRY COUNTY RADI OLOGY	Ŭ	.,		
4.140 4.150	07964 HENRY COUNTY ANESTHESI OLOGY 07965 HENRY COUNTY ANESTHESI OLOGY 07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	0		194 194

	Financial Systems	112	NRY COUNTY MEMO	Provi der CCN: 15-00	30 Period:	eu of Form CMS-2552 Worksheet A-6
					From 01/01/2020 To 12/31/2020	Date/Time Prepare
		Increases				7/30/2021 9:15 am
	Cost Center	Li ne #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - OB/NURSERY/L&D					
00	NURSERY	43.00	522, 538	70, 440		1.
00	DELIVERY ROOM & LABOR ROOM	52.00	18 <u>9, 7</u> 59	2 <u>5, 5</u> 80		2.
	0		712, 297	96, 020		
	B - CAFETERIA					
00		<u>11.00</u>	291, 470	182, 745		1.
			291, 470	182, 745		
00	C - WATERS EXCLUSIONS THE WATERS	194.09	245, 773	148, 929		1.
00	THE WATERS	0.00	245,775	140, 929		2.
00	<u> </u>		245, 773	148, 929		Ζ.
	D - DEPRECIATION POB	I	243,113	140, 727		
00	RENTAL	194.01	0	92, 605		1.
	0			92,605		
	E - EQUIPMENT RENTAL		· · · · ·			
00	NEW CAP REL COSTS-MVBLE	2.00	0	341, 695		1.
	EQUI P					
00		0.00	0	0		2.
00		0.00	0	0		3.
00		0.00	0	0		4.
00		0.00	0	0		5.
00		0.00	0	0		6.
00		0.00	0			7.
	F - IMPLANTABLE DEVICES		U	341, 093		
00	I MPL. DEV. CHARGED TO	72.00	0	5, 480, 052		1.
00	PATIENT	72.00	0	3,400,032		1.
				5, 480, 052		
	I - MEDICAL DIRECTOR RECLASS					
00	NURSING ADMINISTRATION	13.00	25, 000	0		1.
	0		25, 000	<u>0</u>		
	L - MED SUPPLIES RECLASS					
00	MEDI CAL SUPPLIES CHARGED TO	71.00	0	8, 038, 197		1.
	PATI ENTS	+				
			0	8, 038, 197		
00	M – FOREST RIDGE STAFF RECLASS RURAL HEALTH CLINIC	88.00	10, 022	0		1.
00	RURAL HEALTH CLINIC II	88.00	96, 423			2.
00			106, 445	<u>0</u>		2.
	0 - BENEFIT RECLASS		. 50, 110	<u> </u>		
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 327, 451		1.
00		0.00	0	0		2.
00		0.00	0	0		3.
00		0.00	0	0		4.
00		0.00	0	0		5.
00		0.00	0	0		6.
00		0.00	0	0		7.
00		0.00	0	0		8.
00		0.00	0	0		9.
. 00		0.00	0	0		10.
. 00	└ <u>─</u> ── ── ── ── ──	0.00				11.
	P - CAMBRIDGE CITY RECLASS		U	2, 327, 451		
00	CAMBRIDGE CITY	194.10	208, 877	85, 755		1
~~	TOTALS		208, 877	85, 755		<sup>1.</sup>
	IIUIALS					

ECLASSI	inancial Systems FICATIONS		NRY COUNTY MEMO		CCN: 15-0030	Period: From 01/01/2020	u of Form CMS-2552 Worksheet A-6
						To 12/31/2020	Date/Time Prepare 7/30/2021 9:15 am
		Decreases			-	1	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	· ·	
٨	6.00 - OB/NURSERY/L&D	7.00	8.00	9.00	10.00		
	DULTS & PEDIATRICS	30.00	712, 297	96, 020	1	0	1.
. 00		0.00	0	70, 020 0		0	2.
0			712, 297	96, 020		1	2.
В	- CAFETERIA	1			I	1	
. 00 DI	I ETARY	10.00	291, 470	182, 745		0	1.
0			291, 470	182, 745			
	- WATERS EXCLUSIONS				1	-1	
	OUSEKEEPI NG	9.00	25, 033	15, 169		0	1.
	<u>IETARY</u>	<u>10.</u> 00	220, 740	133, 760		o	2.
0	- DEPRECIATION POB		245, 773	148, 929			
	EW CAP REL COSTS-BLDG &	1.00	0	92, 605		9	1.
	IXT	1.00	Ŭ	72,000			
0		+		92,605		-	
E	- EQUIPMENT RENTAL			· · · · · · · · · · · · · · · · · · ·		-	
	URSING ADMINISTRATION	13.00	0	719		9	1.
	EDICAL RECORDS & LIBRARY	16.00	0	694		0	2.
	PERATING ROOM	50.00	0	32, 465		0	3.
	ADI OLOGY-DI AGNOSTI C	54.00	0	283, 577		0	4.
	AGNETIC RESONANCE IMAGING	58.00	0	22, 000		0	5.
	MRI ) ESPI RATORY THERAPY	65.00	o	1, 682		0	6.
	HYSICAL THERAPY	66.00	0	558		0	7.
0			— — — <del>ö</del>	341,695			
F	- IMPLANTABLE DEVICES	I	-1	,	1	1	
. 00 MI	EDICAL SUPPLIES CHARGED TO	71.00	0	5, 480, 052		0	1.
P/	ATI ENTS						
0			0	5, 480, 052			
	- MEDICAL DIRECTOR RECLASS	100.00	05 000		1		
. 00 Pł	HYSICIANS' PRIVATE OFFICES	1 <u>92.00</u>	25,000 25,000	0	<u> </u>	<u>o</u>	1.
	- MED SUPPLIES RECLASS		25,000				
	PERATI NG ROOM	50.00	0	8, 038, 197		0	1.
0			<sub>0</sub>	8, 038, 197			
M	- FOREST RIDGE STAFF RECLAS	S		0,000,177			
	URAL HEALTH CLINIC	88.00	96, 423	C	1	0	1.
. 00 Pł	HYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	1 <u>0, 0</u> 22	Q		o	2.
0			106, 445	C			
	- BENEFIT RECLASS	E ool		0.500	1		
	DMINISTRATIVE & GENERAL HARMACY	5. 00 15. 00	0	2,500		0	1.
	DULTS & PEDIATRICS	30.00	0	197, 510 12, 438		0	2.
	PERATING ROOM	50.00	0	258, 117		0	4.
	URAL HEALTH CLINIC	88.00	0	693, 199		0	5.
	URAL HEALTH CLINIC II	88.01	0	1, 036, 457		0	6.
00 RI	URAL HEALTH CLINIC III	88.02		55, 257		0	7.
	OME HEALTH AGENCY	101.00	0	13, 221		o	8.
	OSPI CE	116.00	0	6, 026		0	9.
	HYSI CLANS' PRI VATE OFFI CES	192.00	0	50, 726		0	10.
1.00 HI	ENRY COUNTY RADI OLOGY	1 <u>94.</u> 14	0	2,000		o	11.
0	- CAMBRIDGE CITY RECLASS		0	2, 327, 451			
	URAL HEALTH CLINIC III	88.02	208, 877	85, 755		0	1.
	OTALS		208, 877	85, 755		Ĭ	''
	rand Total: Decreases		1, 589, 862	16, 793, 449			500.

near tri	Financial Systems HE	NRY COUNTY MEM	ORIAL HOSPITAL			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO		То	od: 01/01/2020 12/31/2020		pared:
				Acquisition	าร			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	46, 000	0		0	0	0	1.00
2.00	Land Improvements	2, 117, 571	0		0	0	5,000	2.00
	Buildings and Fixtures	41, 619, 768	577, 574		0	577, 574		3.00
4.00	Building Improvements	1, 115, 708	782, 514		0	782, 514	0	4.00
5.00	Fixed Equipment	18, 029, 130	4,887,362		0	4, 887, 362	156, 853	5.00
6.00	Movable Equipment	37, 295, 443	7, 725, 672		0	7, 725, 672	6, 759, 743	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	100, 223, 620	13, 973, 122		0	13, 973, 122	7, 036, 654	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	100, 223, 620	13, 973, 122		0	13, 973, 122	7, 036, 654	10.00
		Endi ng	Fully					
		Bal ance	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	46, 000	0					1.00
2.00	Land Improvements	2, 112, 571	0					2.00
	Buildings and Fixtures	42,082,284	0					3.00
	Building Improvements	1, 898, 222	0					4.00
	Fixed Equipment	22, 759, 639	0					5.00
6.00	Movable Equipment	38, 261, 372	0					6.00
	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	107, 160, 088	0					8.00
	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	107, 160, 088	0					10.00

Heal th	Financial Systems H	ENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period:	Worksheet A-7	
					rom 01/01/2020 o 12/31/2020		nared
					0 12/01/2020	7/30/2021 9:1	
			SL	IMMARY OF CAPI	ΓAL		
		D			<b>1</b>	<b>T</b>	
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
		9,00	10.00	11.00	instructions) 12.00	13.00	
-	PART II - RECONCILIATION OF AMOUNTS FROM WOR		10.00	11.00 and 2	12.00	13.00	
1.00	NEW CAP REL COSTS-BLDG & FIXT	5, 119, 704		233, 725	0	0	1.00
2.00	NEW CAP REL COSTS-BEDG & TTXT	5, 119, 704	0	233,723	0	0	2.00
3.00	Total (sum of lines 1-2)	5, 119, 704	0	233, 725	0	0	3.00
5.00		SUMMARY O		200,720	0	0	3.00
		JUNNART					
	Cost Center Description	Other	Total (1)				
		Capital -Relat					
		ed Costs (see					
		instructions)	5 ,				
		14.00	15.00	1			
	PART II - RECONCILIATION OF AMOUNTS FROM WOF	RKSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5, 353, 429				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5, 353, 429				3.00

Health Financial Systems	HENRY COUNTY ME	MORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2020 To 12/31/2020		pared:
	COM	COMPUTATION OF RATIOS		ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITA		-			-	
1.00 NEW CAP REL COSTS-BLDG & FIXT	68, 898, 716		68, 898, 716			1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	38, 261, 372		38, 261, 372			2.00
3.00 Total (sum of lines 1-2)	107, 160, 088		107, 160, 088			3.00
	ALLOCA	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at	cols. 5			
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	(	0 0	0	5, 027, 099	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	(	0 0	0	341, 695	0	2.00
3.00 Total (sum of lines 1-2)	(	0 0	0	5, 368, 794	0	3.00
		SUMMARY OF CAPITAL				
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at	(sum of cols.	
		instructions)		ed Costs (see		
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	105, 965	5 0	C	0 0	5, 133, 064	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	(	0 0	0	0 0	341, 695	2.00
3.00 Total (sum of lines 1-2)	105, 965	5 0	( c	0 0	5, 474, 759	3.00

Health Financial Systems

DJUSTN	IENTS TO EXPENSES			Provider CCN: 15-0030	Period: From 01/01/2020	Worksheet A-8	
					To 12/31/2020	Date/Time Pre 7/30/2021 9:1	pared
				Expense Classification o			
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)				Ref.	
. 00	Investment income - NEW CAP	1.00 A	2.00	3.00 NEW CAP REL COSTS-BLDG &	4.00	5.00	1.0
	REL COSTS-BLDG & FIXT (chapter	A		FIXT	1.00		1.0
	2)						
	Investment income - NEW CAP			NEW CAP REL COSTS-MVBLE	2.00	0	2.0
	REL COSTS-MVBLE EQUIP (chapter 2)			EQUIP			
	Investment income - other		0		0.00	0	3.0
	(chapter 2)	2			5.00		
	Trade, quantity, and time discounts (chapter 8)	В	-4, 882	ADMI NI STRATI VE & GENERAL	5.00	0	4.0
	Refunds and rebates of		0		0.00	0	5.0
	expenses (chapter 8)						
	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.
	Tel ephone services (pay	А	-28, 480	ADMI NI STRATI VE & GENERAL	5.00	0	7.
	stations excluded) (chapter						
	21) Talaviaian and radia convias		0		0.00	о	8.
	Television and radio service (chapter 21)		0		0.00	0	0.1
	Parking lot (chapter 21)		0		0.00	0	9.
	Provider-based physician	A-8-2	-7, 292, 888			0	10.
	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.
	(chapter 23)		0		0.00	0	1
	Related organization	A-8-1	-2, 610, 770			0	12.
	transactions (chapter 10)		0		0.00	0	12
	Laundry and linen service Cafeteria-employees and guests	В	-254.516	CAFETERI A	11.00		13. 14.
	Rental of quarters to employee	5	0		0.00		15.
	and others						
	Sale of medical and surgical supplies to other than		0		0.00	0	16.
	patients						
	Sale of drugs to other than		0		0.00	0	17.
	patients Sale of medical records and	В	6 420	MEDICAL RECORDS & LIBRARY	16.00	0	18.
	abstracts	В	-0, 429	MEDICAL RECORDS & EIBRART	10.00	0	10.
	Nursing and allied health		0		0.00	0	19.
	education (tuition, fees,						
	books, etc.) Vending machines		0		0.00	0	20.
	Income from imposition of		0		0.00		
	interest, finance or penalty						
	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.
	overpayments and borrowings to		0		0.00	0	22.
	repay Medicare overpayments						
	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.
	limitation (chapter 14)						
4.00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.
	therapy costs in excess of						
	limitation (chapter 14) Utilization review –		0	UTILIZATION REVIEW-SNF	114.00		25.
	physicians' compensation		0		111.00		20.
	(chapter 21)						
	Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1.00	0	26.
	COSTS-BLDG & FIXT Depreciation - NEW CAP REL			NEW CAP REL COSTS-MVBLE	2.00	n	27.
	COSTS-MVBLE EQUIP			EQUI P			
	Non-physician Anesthetist		0	*** Cost Center Deleted ***			28.
	Physicians' assistant Adjustment for occupational	A-8-3		OCCUPATI ONAL THERAPY	0.00 67.00		29. 30.
	therapy costs in excess of	A-0-0	0	UCCULATIONAL ITERAFT	07.00		30.
	limitation (chapter 14)						
	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.
	instructions)		ļ	l		l	1

Health Financial Systems	HE	ENRY COUNTY MEN	IORI AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				eri od:	Worksheet A-8	
				rom 01/01/2020		narod
			T	o 12/31/2020	Date/Time Pre 7/30/2021 9:1	
			Expense Classification on	Worksheet A	11/00/2021 1.1	
			To/From Which the Amount is			
				,		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2)				Ref.	
	1.00	2.00	3.00	4.00	5.00	
31.00 Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
pathology costs in excess of						
limitation (chapter 14)						
32.00 CAH HIT Adjustment for		0		0.00	0	32.00
Depreciation and Interest		470		4 00		
33.00 OTHER OP REV - HUMAN RESOURSED	В	-1/8	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
		AF 000		F 00	_	22.01
33. 01 OTHER OP REV - PHY REAPP FEES	B		ADMI NI STRATI VE & GENERAL	5.00		
33. 02 OTHER OP REV	В		HOUSEKEEPI NG	9.00		
33. 03 DI ETARY-OTHER OP REV	В		DIETARY	10.00		33.03
33. 04 OTHER OP REV - PHARMACY	В		PHARMACY	15.00		33.04
33. 05 OTHER OP REV - HEALTH PROGRAM	В		ADULTS & PEDIATRICS	30.00		33.05
33. 06 OTHER OP REV - MEDICAL RECORDS			OPERATI NG ROOM	50.00		33.06
33. 07 OTHER OP REV - LABORATORY-LAB	В	- 1, 330	LABORATORY	60.00	0	33.07
DRUG S		100 041		(/ 00		22.00
33.08 OTHER OP REV - AQUATICS - HLTH	н В	-100, 241	PHYSICAL THERAPY	66.00	0	33.08
PROG 33. 09 OTHER I NCOME		250	CARDI AC REHAB	74 00	0	33.09
	B			76.00		
	В	-892	RURAL HEALTH CLINIC	88.00	0	33.10
MEDICINE-OTHER OP 33.11 OTHER OP REV - NORTHFIELD PARK	в	262 764	RURAL HEALTH CLINIC II	88. 01	0	33.11
33. 12 PUBLIC RELATIONS	A		EMPLOYEE BENEFITS DEPARTMENT	4.00		
33. 13 PUBLIC RELATIONS	A		ADMI NI STRATI VE & GENERAL	5.00		33.12
33. 14 PUBLIC RELATIONS	A		HOUSEKEEPI NG	9.00		33.13
33. 15 PUBLIC RELATIONS	A		NURSING ADMINISTRATION	13.00		33.14
33. 16 PUBLIC RELATIONS	A		ADULTS & PEDIATRICS	30.00		33.15
33. 17 PUBLIC RELATIONS	A		RADI OLOGY-DI AGNOSTI C	54.00		33.10
33. 18 PUBLIC RELATIONS	A		PHYSICAL THERAPY	66.00		
33. 19 PUBLIC RELATIONS	A		RURAL HEALTH CLINIC	88.00		33.18
33. 20 PUBLIC RELATIONS	A		RURAL HEALTH CLINIC II	88.01	0	33.20
33. 21 PUBLIC RELATIONS	A		RURAL HEALTH CLINIC III	88. 02	-	33.20
33. 22 PUBLIC RELATIONS	A		EMERGENCY	91.00		33.21
33. 23 PUBLIC RELATIONS	A		HOME HEALTH AGENCY	101.00		33.22
33. 24 PUBLIC RELATIONS	A		HOSPI CE	116.00	, s	33.23
33. 25 AHA & THA DUES	A		ADMI NI STRATI VE & GENERAL	5.00		33.24
33. 26 BENEFIT EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4.00		
33. 27 NC FAMILY INTERNAL	B		RURAL HEALTH CLINIC	4.00 88.00		
MEDICINE-OTHER OP		-111, 800		00.00		JJ. Z/
33. 28 MEDICAL DIRECTOR	A	90 000	NURSING ADMINISTRATION	13.00	0	33.28
33. 29 HAF EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		
33. 30 PHYSI CI AN RECRUI TMENT	A		ADMINISTRATIVE & GENERAL	5.00	-	
33. 31 PHYSICIAN RECRUITMENT	A		ADULTS & PEDIATRICS	30.00		
33. 32 PHYSICIAN RECRUITMENT	A		OPERATI NG ROOM	50.00		
33. 33 PHYSICIAN RECRUITMENT	A		EMERGENCY	91.00		
50.00 TOTAL (sum of lines 1 thru 49)		-11, 102, 838		71.00	0	50.00
(Transfer to Worksheet A,		11, 102, 030				30.00
column 6, line 200.)						
	1	1	1		1	L

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

Heal th	Financial Systems	HENRY COUNTY ME	MORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0030	Peri od:	Worksheet A-8	-1
OFFI CE	COSTS			From 01/01/2020 To 12/31/2020		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAI MED HOME	
	OFFICE COSTS:					
1.00			RENT EXPENSE	0	14, 795	1.00
2.00			RENT EXPENSE	9, 016	493	2.00
3.00			RENT EXPENSE	208, 771	762, 280	3.00
3.01	58.00	MAGNETIC RESONANCE IMAGING (	RENT EXPENSE	155, 978	450, 000	3.01
3.02	60.00	LABORATORY	RENT EXPENSE	5, 376	34, 208	3.02
4.00	65.00	RESPI RATORY THERAPY	RENT EXPENSE	21, 826	23, 456	4.00
4.01	66.00	PHYSI CAL THERAPY	RENT EXPENSE	162, 399	740, 924	4.01
4.02	88.00	RURAL HEALTH CLINIC	RENT EXPENSE	217, 923	491, 855	4.02
4.03	88.01	RURAL HEALTH CLINIC II	RENT EXPENSE	537,027	1, 245, 010	4.03
4.04	88.02	RURAL HEALTH CLINIC III	RENT EXPENSE	51, 553	142, 041	4.04
4.05	101.00	HOME HEALTH AGENCY	RENT EXPENSE	7,605	22, 481	4.05
4.06	116.00	HOSPI CE	RENT EXPENSE	7,601	22, 480	4.06
4.07	192.00	PHYSICIANS' PRIVATE OFFICES	RENT EXPENSE	2, 928	48, 750	4.07
5.00	TOTALS (sum of lines 1-4).			1, 388, 003	3, 998, 773	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

reriibui					
6.00	G	HENRY COUNTY HO	100.00 HOSPI TAL FOUNDA	100.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or	MISC			100.00
	non-financial) specify:				
					-

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organizati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
			Worksheet A-8-1
OFFICE COSTS		From 01/01/2020 To 12/31/2020	Date/Time Prepared:

			7/30/2021 9:1	15 am
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			1
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME	
	OFFICE COSTS:			1
1.00	-14, 795			1.00
2.00	8, 523	0		2.00
3.00	-553, 509	0		3.00
3.01	-294, 022	0		3.01
3.02	-28, 832	0		3.02
4.00	-1, 630	0		4.00
4.01	-578, 525	0		4.01
4.02	-273, 932	0		4.02
4.03	-707, 983	0		4.03
4.04	-90, 488	0		4.04
4.05	-14, 876	0		4.05
4.06	-14, 879	0		4.06
4.07	-45, 822	0		4.07
5.00	-2, 610, 770			5.00

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

nas not	been posted to worksheet A,	corumns r and/or 2,	the amount	allowable should be	I not cated	In column 4 of	this part.	
	Related Organization(s)							
	and/or Home Office							
	Type of Business							
	51							
	6, 00							
	B. INTERRELATIONSHIP TO RELA	TED OPCANLZATION(S)	AND/OR HOME	OFFLCE				
	D. INTERRELATIONSHIF TO RELA	ILD UNGANIZATION(3)	AND/ OK HOWL	UTTUL.				

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

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

i ci ilibui			
6.00	MISC	6.	. 00
7.00		7.	. 00
8.00		8.	. 00
9.00		9.	. 00
10.00		10.	00
100.00		100.	00
(1) Use	e the following symbols to ind	dicate interrelationship to related organizations:	

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Fi nanci al	Systems	

### HENRY COUNTY MEMORIAL HOSPITAL

nearth	TTHANCTAL Syst	CIIIS	ILINKI COUNTI ML	WORTAL HUSFITA				2552-10
PROVI DI	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (	1	Period: From 01/01/2020 Fo 12/31/2020	) Date/Time Pre	epared:
							7/30/2021 9:1	
	Wkst. A Line #	, , , , , , , , , , , , , , , , , , ,	Total	Professi onal	Provi der		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		NURSING ADMINISTRATION	25,000	0	25, 000			
2.00		ADULTS & PEDIATRICS	3, 065, 081	3, 065, 081	0	211, 500	0	2.00
3.00	50.00	OPERATING ROOM	2, 921, 952	2, 903, 441	18, 511	246, 400	180	3.00
4.00	60.00	LABORATORY	56,000	0	56,000	211, 500	596	4.00
5.00	88. 01	RURAL HEALTH CLINIC II	1, 291, 308	1, 291, 308	0	211, 500	0	5.00
6.00	91.00	EMERGENCY	90,000	0	90, 000	211, 500	560	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00	0.00		7, 449, 341	7, 259, 830	189, 511	0	1 596	200.00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
	WRSt. A LINC #	I denti fi er	Limit	Unadjusted RCE			of Malpractice	
		rdentifier		Limit	Conti nui ng	Share of col.	Insurance	
					Education	12	i fisul ance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		NURSING ADMINISTRATION	26, 438		12.00			1.00
2.00		ADULTS & PEDIATRICS	20, 430	1, 322	-		-	2.00
3.00		OPERATI NG ROOM	21, 323		-	-	0	3.00
3.00 4.00		LABORATORY	60, 603	3, 030		0	0	4.00
		RURAL HEALTH CLINIC II	00, 003	3, 030	0	0	0	
5.00			54 040	0	0	0	0	5.00
6.00		EMERGENCY	56, 942	2, 847	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00	4	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10100
200.00			165, 306			0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		NURSING ADMINISTRATION	0	26, 438		-		1.00
2.00		ADULTS & PEDIATRICS	0	0	0	-,,		2.00
3.00		OPERATING ROOM	0	21, 323		2, 903, 441		3.00
4.00		LABORATORY	0	60, 603	0	0		4.00
5.00		RURAL HEALTH CLINIC II	0	0	0	1, 291, 308		5.00
6.00	91.00	EMERGENCY	0	56, 942	33, 058	33, 058		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	165, 306	33, 058	7, 292, 888		200.00
	I	1		, 000		, , _ , _ , 000	1	

	ENRY COUNTY MEM			In Lie	u of Form CMS-	<u>2552-10</u>
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet B Part I Date/Time Pre 7/30/2021 9:1	epared: 5 am
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	CAPI TAL REL NEW BLDG & FI XT	ATED COSTS NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	col. 7)					
	0	1.00	2.00	4.00	4A	
GENERAL         SERVICE         COST         CENTERS           1.00         00100         NEW         CAP         REL         COSTS-BLDG & FIXT           2.00         00200         NEW         CAP         REL         COSTS-MVBLE         EQUIP           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT         5.00         00500         ADMINISTRATIVE         & GENERAL	5, 133, 064 341, 695 16, 304, 005 14, 029, 694	5, 133, 064 33, 790 701, 696	341, 695 2, 131 44, 257	16, 339, 926	16, 937, 408	1.00 2.00 4.00 5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY	3, 192, 315 444, 824 885, 868 450, 769	1, 332, 618 66, 588 38, 676 140, 495	84, 051 4, 200 2, 439 8, 861	486, 682 0 178, 272	5, 095, 666 515, 612 1, 105, 255 699, 041	7.00 8.00 9.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	219, 699 2, 544, 582 1, 017, 041 4, 130, 164	38, 384 77, 157 139, 230 30, 404	2, 421 4, 866 8, 781 1, 918	94, 869 728, 835 184, 996	355, 373 3, 355, 440 1, 350, 048 4, 162, 486	11.00 13.00 14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	859, 118	45, 021	2, 840		1, 135, 815	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	4, 342, 960	571, 381	36, 038	1, 755, 386	6, 705, 765	30.00
31.00 03100 I NTENSI VE CARE UNI T	1, 786, 193	225, 808	14, 242	465, 894	2, 492, 137	31.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	592, 978	59, 717	3, 766	170, 079	826, 540	43.00
50. 00 05000 OPERATI NG ROOM	3, 634, 911	415, 976	26, 236	1, 636, 344	5, 713, 467	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	215, 339 2, 406, 918	30, 345 220, 377	1, 914 13, 900		309, 362 3, 214, 248	
57. 00 05700 CT SCAN	498, 369	8, 525	538		567, 446	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	289, 097	10, 414 0	657 0		334, 708 0	
60. 00 06000 LABORATORY	5, 107, 558	160, 796	10, 142	-	5, 918, 272	
60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0 1, 112, 022	0 40, 934	0 2, 582	-	0 1, 419, 608	
66. 00 06600 PHYSI CAL THERAPY	1, 835, 988	20, 379	1, 285	503, 417	2, 361, 069	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	238, 322 94, 967	3, 893 3, 757	246 237		314, 738 127, 849	
69. 00 06900 ELECTROCARDI OLOGY	354, 944	3, 737	237		412, 506	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 140, 178 5, 480, 052	0	0	0	2, 140, 178 5, 480, 052	
73. 00 07200 DRUGS CHARGED TO PATIENTS	5, 480, 052	0	0	-	5, 480, 052	1
76.00 03950 CARDI AC REHAB	123, 514	13, 839	873	35, 921	174, 147	76.00
OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C	4, 691, 614	0	0	1, 301, 398	5, 993, 012	88.00
88.01 08801 RURAL HEALTH CLINIC II	7, 943, 462	0	0	2, 495, 574	10, 439, 036	88.01
88. 02   08802   RURAL HEALTH CLINIC III 91. 00   09100   EMERGENCY	433, 609 3, 513, 263	0 205, 701	0 12, 974		528, 790 4, 539, 917	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,010,200	200,701			0	
OTHER REIMBURSABLE COST CENTERS	1, 386, 763	0	0	375, 563	1, 762, 326	101.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF						113.00 114.00
116. 00 11600 HOSPI CE	944, 408		0			116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	98, 720, 267	4, 635, 901	292, 395	15, 764, 992	97, 598, 870	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19, 640	1, 239			190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 HOSPI TALI ST	1, 636, 439	0	0	368, 088	2, 004, 527	192.00 194.00
194. 01 07951 RENTAL	92, 605	0	17, 943	0	110, 548	
194.0507955 OTHER NONREI MBURSABLE COSTS	206, 569	0	0	0	206, 569	194.05
194. 06 07956  DR_AFZAL 194. 07 07957  PHI LLI PS_HALL	4, 402 0	0	0 0	0		194.06 194.07
194.08079580B DRS	0	0	0	0	0	194.08
194. 09 07959 THE WATERS 194. 10 07960 CAMBRI DGE_CI TY	394, 702 294, 632	477, 523 0	30, 118 0		982, 339 362, 619	
194. 11 07961 WELL BEING	294, 032 568	0	0		568	194.11
194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC 194. 13 07963 NEW CASTLE PEDIATRICS	64, 502 0	0	0	0		194.12 194.13
194. 13/07963 NEW CASTLE PEDIATRICS 194. 14/07964 HENRY COUNTY RADIOLOGY	0 1, 620, 170	0	0	0 58, 863	0 1, 679, 033	
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY	0	0	0	0		194, 15

0

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103, 034, 856

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5, 133, 064

0

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0

341, 695

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0

0

16, 339, 926

0 194.15

0 194.16

0 200. 00

0 201.00

103, 034, 856 202.00

In Lieu of Form CMS-2552-10

200.00

201.00

202.00

194. 15 07965 HENRY COUNTY ANESTHESI OLOGY

194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY

TOTAL (sum lines 118 through 201)

Cross Foot Adjustments

Negative Cost Centers

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS Cost Center Description	HENRY COUNTY MEMO	RIAL HOSPITAL Provider CC	F	In Lien rom 01/01/2020 o 12/31/2020 HOUSEKEEPING	u of Form CMS-: Worksheet B Part I Date/Time Pre 7/30/2021 9:1 DIETARY	pared:
	E & GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
1.00 GENERAL SERVICE COST CENTERS						1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	16, 937, 408 1, 002, 440 101, 433	6, 098, 106 93, 578	710, 623			2.00 4.00 5.00 7.00 8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	217, 430 137, 518 69, 910	54, 352 197, 441 53, 942	30, 154 8, 099 0	1, 407, 191 45, 805 13, 983	1, 087, 904 0	9.00 10.00 11.00
13.00         01300         NURSI NG ADMI NI STRATI ON           14.00         01400         CENTRAL SERVI CES & SUPPLY           15.00         01500         PHARMACY           16.00         01600         MEDI CAL RECORDS & LI BRARY	660, 096 265, 587 818, 861 223, 442	108, 431 195, 663 42, 727 63, 270	0 0 0 0	4, 822 11, 813	0 0 0 0	13.00 14.00 15.00 16.00
16.00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTE		03,270		4, 022	0	10.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSIVE CARE UNIT 43. 00 04300 NURSERY	1, 319, 185 490, 263 162, 600	802, 976 317, 334 83, 922	143, 533 32, 339 10, 376	92, 334	897, 339 190, 565 0	30.00 31.00 43.00
ANCILLARY SERVICE COST CENTERS						
50.00         05000         OPERATI NG ROOM           52.00         05200         DELI VERY ROOM & LABOR ROOM           54.00         05400         RADI OLOGY-DI AGNOSTI C           57.00         05700         CT SCAN           58.00         05800         MAGNETI C RESONANCE I MAGI NG (MRI	1, 123, 976 60, 859 632, 320 111, 630 ) 65, 845	584, 582 42, 645 309, 702 11, 981 14, 634	127, 765 3, 747 51, 711 0 0	0 54, 967 0	0 0 0 0 0	50.00 52.00 54.00 57.00 58.00
59.00         05900         CARDI AC         CATHETERI ZATI ON           60.00         06000         LABORATORY         60.01         06001         BLOOD         LABORATORY           65.00         06500         RESPI RATORY         THERAPY	0 1, 164, 266 0 279, 271	0 225, 971 0 79, 135	C 899 C C	0 16, 635 0	0 0 0 0	59.00 60.00 60.01 65.00
66.00         06600         PHYSI CAL THERAPY           67.00         06700         OCCUPATI ONAL THERAPY           68.00         06800         SPEECH PATHOLOGY           69.00         06900         ELECTROCARDI OLOGY	464, 479 61, 917 25, 151 81, 150	716, 291 5, 471 5, 279 0	13, 695 1, 954 C C	107, 281 15, 188 0	0 0 0 0	66.00 67.00 68.00 69.00
71.0007100MEDI CALSUPPLI ESCHARGED TOPAT72.0007200I MPL.DEV.CHARGED TOPATI ENT73.0007300DRUGSCHARGED TOPATI ENTS76.0003950CARDI ACREHAB	FLENTS 421, 024 1, 078, 058 0 34, 259	0 0 0 19, 449	0 0 0 0	0	0 0 0 0	71.00 72.00 73.00 76.00
OUTPATIENT SERVICE COST CENTERS	4 470 0(0	404 040	4 440	40.077		
88.00 08800 RURAL HEALTH CLINIC 88.01 08801 RURAL HEALTH CLINIC II 88.02 08802 RURAL HEALTH CLINIC III 91.00 09100 EMERGENCY	1, 178, 969 2, 053, 582 104, 026 893, 111	431, 263 1, 114, 758 81, 378 289, 077	4, 418 2, 130 0 127, 298	132, 113 0	0 0 0 0	88.00 88.01 88.02 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	PART)					92.00
OTHER REIMBURSABLE COST CENTERS	346, 692	62, 641	C	9, 643	0	101.00
SPECIAL PURPOSE COST CENTERS	0.0,072	02,011		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 116.00 11600 HOSPICE	218, 669	62, 613				113.00 114.00 116.00
118.00 SUBTOTALS (SUM OF LINES 1 throu NONREI MBURSABLE COST CENTERS		6, 070, 506	558, 118	1, 274, 837	1, 087, 904	110.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CAI 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950 HOSPI TALI ST	ITEEN 4, 107 394, 339 0	27, 600 0 0	C C C	0	0	190. 00 192. 00 194. 00
194. 01 07951 RENTAL 194. 05 07955 OTHER NONREI MBURSABLE COSTS 194. 06 07956 DR AFZAL	21, 747 40, 637 866	0 0 0	0 13, 270 0	0	0 0	194. 01 194. 05 194. 06
194. 07 07957 PHILLIPS HALL 194. 08 07958 0B DRS 194. 09 07959 THE WATERS 194. 10 07960 CAMBRI DGE CITY	0 0 193, 250 71, 336	0 0 0 0	5, 771 9, 536 123, 928 0	0 0 0	0 0 0	194.07 194.08 194.09 194.10
194. 11 07961 WELL BEING 194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC 194. 13 07963 NEW CASTLE PEDIATRICS 194. 14 07964 HENRY COUNTY RADIOLOGY 194. 15 07965 HENRY COUNTY ANESTHESIOLOGY 194. 16 07966 NEW CASTLE IMMEDICATE CARE & F/	0 330, 306 0	0 0 0 0 0 0			0 0 0 0	194. 11 194. 12 194. 13 194. 14 194. 15 194. 16
200.00Cross Foot Adjustments201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 20	0 01) 16, 937, 408	0 6, 098, 106	0 710, 623	0 1, 407, 191		200. 00 201. 00 202. 00

Heal th	Financial Systems HE	NRY COUNTY MEN	IORI AL HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0030 F	Period: From 01/01/2020	Worksheet B Part I	
					To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS				1		
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA	493, 208					11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	37, 508 11, 989		1, 828, 109			13.00
15.00	01500 PHARMACY	0		3, 353			15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	23, 162	0	518	3 0	1, 451, 029	16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	92, 084	780, 306	47,023	3 0	135, 050	30.00
31.00	03100 I NTENSI VE CARE UNI T	28, 368		16, 140		61, 166	
43.00	04300 NURSERY	9, 046	76, 650	4, 730	0 0	46, 632	43.00
50, 00	ANCI LLARY SERVI CE COST CENTERS	76, 490	648, 153	109, 732	2 0	250, 112	50.00
50.00 52.00	05000 DELIVERY ROOM & LABOR ROOM	3, 285		1, 718	-	250, 112	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	37, 037		25, 342		176, 231	54.00
57.00	05700 CT SCAN	3, 562		14,676		79, 940	•
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	2, 479 0	-	2, 727 (		21, 196 0	58.00 59.00
60.00	06000 LABORATORY	52, 644		230, 279	-	248, 904	60.00
60.01	06001 BLOOD LABORATORY	0	-	C	-	0	60.01
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	17, 022 36, 411		5, 231 5, 225		14, 535 9, 690	
67.00	06700 OCCUPATI ONAL THERAPY	4, 155		5, 225		9,890	67.00
68.00	06800 SPEECH PATHOLOGY	1, 439		C		606	
69.00	06900 ELECTROCARDI OLOGY	3, 310		7, 795		15, 746	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0		352, 974 906, 123		46, 632 61, 772	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	/00, 120		01,772	1
76.00	03950 CARDI AC REHAB	2, 942	24, 926	536	o 0	2, 422	76.00
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	726, 509	7, 820	0	10, 295	88.00
88.00	08801 RURAL HEALTH CLINIC II	0		13, 831		35, 731	88.00
88.02	08802 RURAL HEALTH CLINIC III	0		2, 135	5 0	0	88.02
91.00	09100 EMERGENCY	50, 275	426, 015	64, 542	2 0	221, 046	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	0	0	3, 602	2 0	7, 267	101.00
	SPECIAL PURPOSE COST CENTERS	[	1		I I I I I I I I I I I I I I I I I I I		
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113.00 114.00
	11600 HOSPI CE	0	0	2,057	0	4, 239	116.00
118.00		493, 208	4, 168, 707	1, 828, 109	5, 039, 240	1, 451, 029	118.00
100 00	NONREIMBURSABLE COST CENTERS	0	0			0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES			C			190.00
194.00	07950 HOSPI TALI ST	0	0	C		0	194.00
	07951 RENTAL	0	0	0			194.01
	07955 OTHER NONREI MBURSABLE COSTS 07956 DR AFZAL		0	(	-		194.05 194.06
	07957 PHI LLI PS HALL	0	0	C	0		194.07
	07958 OB DRS	0	0	C	0 0		194.08
	07959 THE WATERS 07960 CAMBRI DGE CI TY	0	0	0			194.09 194.10
	07961 WELL BEING	0	0	0			194.10
194.12	07962 ACTIVATE HEALTH EMPLOYER CLINIC	0	o o	C	0	0	194.12
194.13	07963 NEW CASTLE PEDIATRICS	0	0	0	0		194.13
	07964 HENRY COUNTY RADI OLOGY 07965 HENRY COUNTY ANESTHESI OLOGY		0	(			194.14 194.15
	07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	(			194.15
200.00	Cross Foot Adjustments						200.00
201.00	ů – C	402 200	0 4, 168, 707	0 1, 828, 109			201.00
202.00	I TOTAL (Sum TITIES TTO THE OUGH 201)	493, 208	4, 100, 707	1,020,105	5, 039, 240	1, 401, 029	1202.00

To         12/31/2001         Description         Tetra A Besidentis Data & Powel All Ustreamts         Total Data & Powel All Ustreamts         Total Data & Powel All Ustreamts         Total Data & Powel Processor         Total Data & Powel Processor         Total Data & Powel Processor         Total Data & Powel Processor         Description         Description           1:00         Processor         Status Tetra Data & Powel Processor         20.00         20.00         20.00         20.00           1:00         Octool Ustream Data Processor         Description         21.00         20.00         20.00           1:00         Octool Ustream Data Processor         Description         20.00         20.00         20.00           1:00         Octool Ustream Data Processor         Description         20.00	Heal th Financial Systems         HE           COST ALLOCATION - GENERAL SERVICE COSTS         HE	ENRY COUNTY MEN		CN: 15-0030	Period: From 01/01/2020	<u>of Form CMS-2552-10</u> Worksheet B Part I
Cost Conter Description         Sublicital Description         Total Reprint Description         Total Reprint Description           1.00         Cost Conter Description         2.00         25.00         26.00           1.00         Cost Cost Cost Cost Cost Cost Description         2.00         25.00         26.00           1.00         Cost Cost Cost Cost Cost Description         2.00         25.00         26.00           1.00         Cost Cost Cost Cost Cost Description         2.00         2.00         2.00         2.00           1.00         Cost Cost Cost Cost Description         2.00         2.						Date/Time Prepared:
Image: Description of the set of	Cost Center Description		Residents Cost & Post Stepdown Adjustments			7/30/2021 9. 15 am
1.00         DDIOQ INF CAP ERL COSTS HURG A FIXT         1           0.00         DDIOQ INF CAP ERL COSTS HURG A FIXT         4           4.00         CORO DEMUNDER EXPERTITS DEPARTMENT         4           4.00         DDIOQ INF CAP ERL COSTS HURG A FIXT         4           6.00         DDIOQ INFERSITIO B CPARTMENT         7           6.00         DDIOQ INFERSITIO B CPARTMENT         7           6.00         DDIOQ INFERSITIO B CPARTMENT         7           7.00         DIOQ INFERSITIO B CPARTMENT         7           7.00         DIOQ INFERSITIO CONTICENTERS         7           7.00         DIOQ INFERSITION         1         1.00           7.00         DIOQ INFERSITION         1         1.00	CENEDAL SERVICE COST CENTERS	24.00	25.00	26.00		
4 400 DODG EPRLOYCE BENEFITS DEPARTMENT 5 00 DODG OF RATIO OF PLANT 7 00 DOTX OF RATION OF PLANT 1 10 DOTX OF RATION OF PLANT 1 11 DOTX NURSHEE ALLOW SERVICE 1 00 DOTX OF PLANT 1 00 DOTX OF PLANT 1 11 DOTX NURSHEE ALLOW SERVICE 1 00 DOTX OF PLANT 1 00 DOTX OF PLANT 1 11 DOTX NURSHEE ALLOW SERVICE 1 00 DOTX OF PLANT 1 11 DOTX NURSHEE ALLOW SERVICE 1 00 DOTX OF PLANT 1 11 DOTX NURSHEE ALLOW SERVICE 1 1 00 DOTX OF PLANT 1 11 DOTX NURSHEE ALLOW SERVICE 1 1 00 DOTX OF PLANT 1 11 DOTX NURSHEE ALLOW SERVICE 1 1 200 DOTX OF PLANT 1 12 DOTX OF PLANT 1 2 D						1.00
31:00       03100 [NTERSIN VE CARE UNIT       3, 661, 032       0       3, 764, 032       3, 744, 745, 745         AND       04300 (NTERSIN VE COST CENTERS	2.00         00200         NEW CAP REL COSTS-MVBLE EQUIP           4.00         00400         EMPLOYEE BENEFITS DEPARTMENT           5.00         00500         ADMI NI STRATI VE & GENERAL           7.00         00700         OPERATI ON OF PLANT           8.00         00800         LAUNDRY & LI NEN SERVI CE           9.00         00900         HOUSEKEEPI NG           10.00         DI ETARY           11.00         O1100           01300         NURSI NG ADMI NI STRATI ON           14.00         O1400           CENTRAL SERVI CES & SUPPLY           15.00         01500           PHARMACY           16.00         MEDI CAL RECORDS & LI BRARY					2.00 4.00 5.00 7.00 9.00 10.00 11.00 13.00 14.00 15.00
43. 00       0.3000_NURSERY       1, 227, 246       0       1, 227, 246       43         44. 00       1, 227, 246       0       1, 227, 246       44         45. 00       05000       OPERATING ROOM       8, 613, 159       0       8, 613, 159       55         50. 00       05000       OPERATING ROOM       449, 454       0       449, 454       52         54. 00       05400       RADIOLOX-DI AGMOSTIC       4, 501, 558       0       4, 501, 558       57         58. 00       05800       MAGKITIC RESONANCE ILAGING (MRI)       441, 589       0       441, 589       57         60. 00       000000       LABORATORY       7, 557, 870       0       7, 557, 870       60						30.00
AUCILLARY SERVICE COST CENTRES           00         05000 (DFRATI INE ROAM         8.813.159         0         8.813.159         55           52.00         05200 (DFRATI INE ROAM         4.94,9454         0         449,454         55           57.00         05200 (DELI VERY ROAM & LABOR ROAM         1441,559         57         00         550         57           59.00         05000 (CT SCAN         739,235         739,235         739,235         57           50.00         05000 (ARDI AC CATHEER) XATI NN         0         0         0         0         60           60.01         06000 (DECH LABORATORY         0         0         0         0         66           60.00         06000 (DECH TIERAPY         1, 949,277         65         66         06500 (PHRSI CAL, THERAPY         3, 714, 141         0         3, 714, 141         66         06400 (SPREST HATORY THERAPY         1, 949, 277         65         66         06400 (DELCH TICARANI DIS CMARED TO PATI ENTS         2, 52, 524         160, 524         66         00         66000 (PHRSI CAL, THERAPY         1, 949, 277         60         73         73         73         73         73         73         73         73         73         73         74         160, 524 <t< td=""><td></td><td></td><td>-</td><td></td><td></td><td>31.00 43.00</td></t<>			-			31.00 43.00
52.00         65200         61200         DELLYERY ROM & LABOR ROM         449, 454         62           52.00         05700         CTSON ACROSTIC         4, 501, 556         64           57.00         05700         CTSSONNCE 1MAGING (MR)         789, 235         57           59.00         05000         CARDIAC CATHETERIZATION         0         0         60           00         05000         CARDIAC CATHETERIZATION         0         0         0         0           60.01         060001         LABORATORY         0         7, 857, 870         0         60           60.00         060001         CARDIARC CATHETERIZATION         0	ANCILLARY SERVICE COST CENTERS		-			
54.00         05400 [RADIOLOCY-DIACNOSTIC         4, 501, 558         0         4, 501, 558         779, 235         779, 235         57           58.00         05000 [ARGHETIC RESONANCE IWAGING (WRI )         441, 589         58         0         779, 235         57           59.00         05000 [ARDIAC CATHERERIZATION         0         0         0         0         59           60.00         06000 [ARDIAC CATHERERIZATION         7, 857, 870         0         7, 857, 870         60           00         05500 [RESPI RATORY THERAPY         1, 849, 277         0         1, 849, 277         65           60.00         06000 [PHYSIGLA THERAPY         3, 714, 141         0         3, 714, 141         66           61.00         06000 [PHYSIGLA THERAPY         3, 714, 141         0         3, 714, 141         66           61.00         06000 [PHYSIGLA THERAPY         160, 324         0         160, 324         68          69.00         06000 [PHICLALSUPPLIES CHARGED TO PATIENT         7, 526, 005         72         73           72.00         07300 [PHICLALSUPPLIES CHARGED TO PATIENT         7, 526, 005         73         73         73           73.00         07300 [PHICLALSUPPLIES CHARGED TO PATIENT         7, 526, 005         73         73						50.00 52.00
58. 00         05800 MAGNETIC RESONANCE IMAGING (MRI)         441,589         0         441,589         58.           50. 00         0500 CARDIA CATHETERIZATION         0         0         0         600           60.00         06000 LABORATORY         7,857,870         0         7,857,870         600           60.00         06000 PHYSICAL THERENY         1,849,277         0         1,849,277         65           60.00         06000 PHYSICAL THERAPY         3,714,141         0         3,714,141         66           60.00         06000 SPECCH PAINOLOGY         160,324         0         160,324         66           60.00         06000 DRIS CHARGED TO PATIENT         7,526,030         7,526,005         7,729,843         88						54.00
59.00         05900 CARDIA C CATHETERI XATION         0         0         0         59           60.00         06000 LABORATORY         7, 557, 670         0         7, 557, 870         0						57.00
60.00         06000 LABORATORY         7, 857, 870         0         7, 857, 870         0         60.00           00.01         06000 RESPI RATORY THERAPY         1, 849, 277         0         1, 849, 277         65           0.00         06000 PHYSICAL THERAPY         3, 714, 141         0         3, 714, 141         65           0.00         06000 SPECIP ANTINERAPY         3, 714, 141         0         3, 714, 141         66           0.00         06000 SPECIP ANTINERAPY         405, 240         0         405, 240         66           0.00         06000 SPECIP ANTINERAPY         525, 329         0         525, 329         69           0.00         0700 DINEL CALSUPPLIES CHARGED TO PATIENT S         5, 050, 90, 200         7, 526, 005         7, 752, 643         88         80         800			-			58.00 59.00
60.01         06001         06001         06001         06000         0600         0600         0600         PESPIRATORY THERAPY         1, 849, 277         0         1, 849, 277         65           66.00         06600         PESPIRATORY THERAPY         3, 714, 141         0         3, 714, 141         66           67.00         06700         0CUDATI NULL THERAPY         405, 240         0         1403, 224         66           68.00         0COD OCUDATI NULL THERAPY         405, 240         0         140, 324         66           70.00         0COD CLECTROCARDI OLOCY         525, 329         0         525, 329         69           71.00         0TOID MEDI CELCTROCARDE TO PATI ENT         7, 526, 005         7, 7, 526, 005         7, 72, 628, 681         76           72.00         07300         DRUSS CHARGED TO PATI ENT         5, 526, 605         77, 526, 005         77         78, 80         78         78         0         78, 681         76         78         88         0         0800 RURAL HEALTH CLI N C II         14, 945, 591         14, 945, 591         88         88         0         88, 00         88, 00         88, 00         880, 00         880, 00         88, 00         880,00         880,00         89,01,63		-	-		-	60.00
66.00         06600         PHYSICAL THERAPY         3, 714, 141         0         3, 714, 141         66           67.00         06700         OCCUPATIONAL THERAPY         405, 240         67           68.00         06800         SPEECH PATHOLOGY         160, 324         67           69.00         06900         ELCTROCADOL OLOGY         525, 329         0         525, 329         69           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         2, 960, 808         0         2, 960, 808         77           72.00         07200         IPLD EV, CHARGED TO PATIENTS         5, 039, 240         5, 039, 240         76         0         258, 681         0         26, 868         77           76.00         06800         RURAL HEALTH CLINIC         8, 396, 163         0         8, 396, 163         88         88         0         88, 01         6800         RURAL HEALTH CLINIC         88         89         0         88, 02         88         0         88, 02         88         0         97, 943         0         77, 943         88           80.00         08000         RURAL HEALTH CLINIC THAT         773, 843         0         779, 843         0         779, 843         0         799, 931 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>60.01</td>		0	0		0	60.01
67.00         06700         0CCUPATIONAL THERAPY         405,240         405,240         67           68.00         06800         SPEECH PATHOLOGY         160,324         0         160,324         68           69.00         06900         ELECTROCADDIOLOGY         525,329         69         67         00         700         00         670.00         710.00			-			65.00 66.00
69.00         06900         ELECTROCARD 0LOGY         525, 329         0         525, 329         69           10.0         07100         MPLL         DEVLARGED TO PATIENTS         2, 900, 808         0         2, 900, 808         71           72.00         07200         MPLL         DEV. CHARGED TO PATIENTS         5, 039, 240         0         5, 039, 240         73           73.00         07300         CRUSC CHARGE TO PATIENTS         5, 039, 240         0         5, 039, 240         73           70.00         07300         CRUSC CHARGE TO PATIENTS         5, 039, 240         0         5, 039, 240         73           70.00         07000         RURAL HEALTH CLINIC I         8, 396, 163         0         8, 396, 163         88         80.00         08000         RURAL HEALTH CLINIC III         14, 945, 591         88           71.00         09100         EMERGENCY         6, 723, 625         0         6, 723, 625         91         92         92         90         9200 OBSERVATION BEDS (NON-DISTINCT PART)         0         1, 399, 131         113         113         113         113         113         10         11400         1400         1400         140         140         140         140         140         140<			-			67.00
11.00       07100       MCDI CAL. SUPPLIES CHARGED TO PATIENTS       2, 960, 808       0       2, 960, 808       7, 526, 005       8, 396, 163       8, 396, 163       88       88       0, 8000       RURAL HEALTH CLINIC I I       14, 945, 591       0       4, 945, 591       88       88       0, 0000       6, 723, 625       0       6, 723, 625       91       91       90, 000       0, 000       0, 000       9000       0, 000       9000       9000       9000       9000       9000       9000       90, 900       90, 900       90, 900       90, 900       90, 900       90, 900       900       900       900       900       900       900       900       900       900       900       900       900 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>68.00</td></td<>						68.00
72.00       072.00       IVPL. DEV. CHARGED TO PATIENT       7, 526, 005       9       7, 526, 005       73         73.00       07300       000 DRUGS CHARGED TO PATIENTS       5, 039, 240       0       5, 039, 240       73         76.00       03950       CARDIAC REHAB       258, 681       0       258, 681       76         0UTPATIENT SERVICE COST CENTERS       0       8, 396, 163       0       8, 396, 163       88         80.0       08000 RURAL HEALTH CLINIC 111       14, 945, 591       0       14, 945, 591       88         91.00       091000 EWREGENCY       6, 723, 625       0       6, 723, 625       91         92.00       09200 OBSERVATION BEDS (NON-DI STINCT PART)       0       2, 192, 171       0       2, 192, 171       10         SPECIAL PURPOSE COST CENTERS         113.00       11700 HOME HEALTH ALGENCY       2, 192, 171       0       2, 192, 171       11         SUBTOTALS (SUM OF LINES 1 through 117)       9, 217, 022       9, 62, 17, 022       113       114         113.00       1100 HOME HEALTH ALENCY       2, 398, 666       2, 398, 866       192         0       100100 GIF, FLOWER, COFFEE SHOP & CANTEEN       5, 720       5, 720       120 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>69.00 71.00</td>						69.00 71.00
73.00       OT300 DRUSS CHARGED TO PATLENTS       5.039, 240       0       5.039, 240       76         76.00       O350 CARDLAC REHAB       258, 681       0       258, 681       76         0UTPATLENT SERVICE COST CENTERS       8.396, 163       0       8, 396, 163       88         88.01       08007 RURAL HEALTH CLINIC II       14, 4945, 591       0       14, 945, 591       88         88.02       088027 RURAL HEALTH CLINIC III       779, 843       0       779, 843       88         10.00       0000 EMERGENCY       6, 723, 625       0       6, 723, 625       91         92.00       09200 IDSERVATION BEDS (NON-DISTINCT PART)       0       2, 192, 171       0       2, 192, 171       101         SPECIAL PURPOSE COST CENTERS         113         113         000011000 INTEREST EXPENSE       113         113         000011000 GIFT, FLOWER, COFTER SHOP & CANTEEN       114         113         00001200 OR STOR CENTERS       113         113         113       14.000 11400 UTILIZATION REVIEW-SNF       133       1, 399, 131       1, 399, 131       1, 399, 131       14, 945, 917						71.00
OUTPATLENT SERVICE COST CENTERS           98.00         08800 RURAL HEALTH CLINIC         8.396,163         0         8.396,163         88           98.01         08801 RURAL HEALTH CLINIC II         14,945,591         0         14,945,591         88           91.00         09100 EMERGENCY         0         14,945,591         0         779,843         91           92.00         092000 DESERVATION BEDS (NON-DISTINCT PART)         0         6,723,625         0         6,723,625         91           91.00         01100 HOME HEALTH AGENCY         2,192,171         0         2,192,171         101           101.00         10100 HOME HEALTH AGENCY         2,192,171         0         2,192,171         113           101.00         10100 HOME HEALTH AGENCY         1,399,131         0         1,399,131         114           10.00 11300 INTEREST EXPENSE         113         114         00         1,399,131         0         1,399,131         116           118         00         SUBTOTALS (SUM OF LINES 1 through 117)         96,217,022         96,217,022         113           104.00 07150 INTERNEST EXPENSE         1,399,131         0         1,399,131         114         16           118         00         0000 GIFT, FLOWER COF	73.00 07300 DRUGS CHARGED TO PATIENTS					73.00
88 00       08800       RURAL HEALTH CLINIC       8. 396, 163       0       8. 396, 163       88         88 01       08801       RURAL HEALTH CLINIC III       14, 945, 591       0       14, 945, 591       88         88 02       08802       RURAL HEALTH CLINIC III       14, 945, 591       0       14, 945, 591       88         88 02       08802       RURAL HEALTH CLINIC III       14, 945, 591       0       6, 723, 625       91         92 00       092000       095EVATION BEDS (NON-DISTINCT PART)       0       2, 192, 171       0       2, 192, 171       0       92         01000       10100       HOME HEALTH AGENCY       2, 192, 171       0       2, 192, 171       0       2, 192, 171       0       113       113       113       113       113       113       114, 00 11400       UTILIZATION REVIEW-SNF       114       116       116       116       116       1399, 131       0       1, 399, 131       116       118       100       1000       USUTALS (SUM OF LINES 1 through 117)       96, 217, 022       0       96, 217, 022       190       190       190       190       190       190       190       190       120       190       190       1,399, 131       116       116		258, 681	0	258, 6	31	76.00
88 01       08001       RURAL HEALTH CLINIC II       14,945,591       0       14,945,591       88         88. 02       08002 RURAL HEALTH CLINIC III       779,843       0       779,843       88         91.00       09100 EMERGENCY       0       6,723,625       91         0       01000 HOME HEALTH AGENCY       2,192,171       0       2,192,171       101         0       01000 HOME HEALTH AGENCY       2,192,171       0       2,192,171       111         10.00       10100 HOME HEALTH AGENCY       2,192,171       0       1,399,131       114         113.00       11300 INTEREST EXPENSE       113       114       114       114       11400 UTILIZATION REVIEW-SNF       113       114         116.00       10000 GIFT, FLOWER, COFFEE SHOP & CANTEEN       55,720       55,720       190       19000         190.00       19200 PHYSICIANS' PRIVATE OFFICES       2,398,866       192       194		8, 396, 163	0	8, 396, 10	53	88.00
91.0       09100       EURRCENCY       6, 723, 625       0       6, 723, 625       91         92.00       092000       DBSERVATION BEDS (NON-DISTINCT PART)       0       0       92       91         0THER       RELIMBURSABLE COST CENTERS       0       2, 192, 171       0       2, 192, 171       101         SPECIAL PURPOSE COST CENTERS         113.00       I1300       INTEREST EXPENSE       113       114       11400       0       1, 399, 131       0       1, 399, 131       116         118.00       11300       INTEREST EXPENSE       114       116       116       1180       0       1, 399, 131       0       1, 399, 131       116         118.00       10000 GIFT, FLOWER, COST CENTERS       118       118       118       118       118       116       118       119       119       119 <td></td> <td></td> <td></td> <td></td> <td></td> <td>88.01</td>						88.01
92.00         09200 [0BSERVATION BEDS (NON-DISTINCT PART)         0         92           0THER REI MBURSABLE COST CENTERS         111<						88.02
OTHER REI MBURSABLE COST CENTERS           101.00         10100/HOME HEALTH AGENCY         2, 192, 171         0         2, 192, 171         101           SPECIAL PURPOSE COST CENTERS           113.00         11300 INTEREST EXPENSE         113         114         112         114         112         112         114         1		6, 723, 625			25	91.00 92.00
SPECIAL PURPOSE COST CENTERS         113.00         INTEREST EXPENSE         113           114.00         ITLIZATION REVIEW-SNF         113         114           116.00         11600         HOSPICE         1, 399, 131         0         1, 399, 131         116           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         96, 217, 022         0         96, 217, 022         118           NONE I MBURSABLE COST CENTERS         100         0         55, 720         0         96, 217, 022         190           190.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         2, 398, 866         0         2, 398, 866         192           194.01         00         0         0         0         0         194           194.01         07950         HOSPI TAL ST         0         0         194           194.01         07955         OTHER NONREI MBURSABLE COSTS         260, 476         0         260, 476           194.05         07955         OTHER NONREI MBURSABLE COSTS         260, 476         0         260, 476         194           194.06         07956         DR AFZAL         5, 268         0         5, 268         194           194.07         07957         PHILLIPS <t< td=""><td>OTHER REIMBURSABLE COST CENTERS</td><td></td><td></td><td>1</td><td></td><td></td></t<>	OTHER REIMBURSABLE COST CENTERS			1		
113.00       INTEREST EXPENSE       113         114.00       IT400       UTL LZATION REVIEW-SNF       113         116.00       IOSPICE       1,399,131       0       1,399,131         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       96,217,022       0       96,217,022         NONRE IMBURSABLE COST CENTERS         190.00       IFT, FLOWER, COFFEE SHOP & CANTEEN       55,720       0       55,720         192.00       19200       PHYSI CLANS' PRI VATE OFFICES       2,398,866       0       2,398,866         194.01       07950       PHSTALLST       0       0       0       0         194.01       07955       OTHER NONREI MBURSABLE COSTS       260,476       0       252,595       194         194.06       07957       PHI LLIPS HALL       14,691       0       14,691       194         194.08       07957       PHI LLIPS HALL       14,691       0       14,691       194         194.09       07959       THE WATERS       1,299,517       0       1,299,517       194         194.09       07958       D RS       9,536       0       9,536       194         194.194.09       07960       CAMBRI DGE CITY       433,955<		2, 192, 171	0	2, 192, 1	71	101.00
114.00       UTI LI ZATI ON REVI EW-SNF       1, 399, 131       0       1, 399, 131       114         116.00       HOSPI CE       1, 399, 131       0       1, 399, 131       116         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       96, 217, 022       0       96, 217, 022       118         NONREI MBURSABLE COST CENTERS         190.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN       55, 720       0       55, 720       190         192.00       19200       PHYSI CLANS' PRI VATE OFFI CES       2, 398, 866       0       2, 398, 866       192         194.01       07950       HOSPI TALL ST       0       0       0       194         194.05       07955       OTHER NORREI MBURSABLE COSTS       260, 476       260, 476       194         194.05       07956       DR AFZAL       5, 268       0       5, 268       194         194.06       07956       DR AFZAL       14, 691       144, 691       194         194.09       07959       THE WATERS       1, 299, 517       194       194         194.10       0760       CAMBRIDGE CI TY       433, 955       194       194       194       194       194       194       194       194       <						113.00
118.00         SUBTOTALS (SUM OF LINES 1 through 117)         96, 217, 022         0         96, 217, 022         118           NONREL MEURSABLE COST CENTERS						114.00
NONREI MBURSABLE         COST         CENTERS         CONTREI						116.00 118.00
190.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN       55,720       0       55,720       190         192.00       19200       PHYSI CLANS' PRI VATE OFFICES       2,398,866       0       2,398,866       192         194.00       07950       HOSPI TALI ST       0       0       0       0       194         194.01       07951       RENTAL       252,595       0       252,595       194         194.05       07955       OTHER NONREI MBURSABLE COSTS       260,476       0       260,476       194         194.05       07957       DR AFZAL       5,268       0       5,268       194         194.08       07958       DB RS       9,536       0       9,536       194         194.09       07959       THE WATERS       1,299,517       1,299,517       194         194.10       07960       CAMBRI DGE CI TY       433,955       0       433,955       194         194.12       07962       ACTI VATE HEALTH EMPLOYER CLI NI C       77,191       0       77,191       194         194.13       07963       NEW CASTLE PEDI ATRI CS       0       0       0       0       194         194.14       07966       HENRY COUNTY RADI OLOGY       <		90, 217, 022		y 90, 217, 0.	22	110.00
194.00       07950       HOSPI TALIST       0       0       194         194.01       07951       RENTAL       252,595       0       252,595       194         194.05       07955       OTHER NONREI MBURSABLE COSTS       260,476       0       260,476       194         194.06       07956       DR AFZAL       5,268       0       5,268       194         194.07       07957       PHI LLI PS HALL       14,691       0       14,691       194         194.08       07958       DB DRS       9,536       0       9,536       194         194.10       07960       CAMBRI DGE CI TY       433,955       0       433,955       194         194.11       07961       WELL BEING       680       0       680       194         194.12       07962       ACTI VATE HEALTH EMPLOYER CLINIC       77,191       0       77,191       194         194.13       07963       NEW CASTLE PEDI ATRICS       0       0       0       194         194.14       07964       HENRY COUNTY RADIOLOGY       2,009,339       2,009,339       194         194.15       07965       HENRY COUNTY ANESTHESI OLOGY       0       0       0       194     <	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	55, 720	0	55, 7	20	190.00
194.01       07951       RENTAL       252,595       0       252,595       194         194.05       07955       OTHER NONREI MBURSABLE COSTS       260,476       0       260,476       194         194.06       07956       DR AFZAL       5,268       0       5,268       194         194.07       07957       PHI LLI PS HALL       14,691       0       14,691       194         194.08       07958       0B DRS       9,536       0       9,536       194         194.09       07959       THE WATERS       1,299,517       1,299,517       194         194.10       07060       CAMBRI DGE CI TY       433,955       0       433,955       194         194.11       07961       WELL BEING       680       0       680       194         194.12       07962       ACTI VATE HEALTH EMPLOYER CLINIC       77,191       0       77,191       194         194.13       07963       NEW CASTLE PEDI ATRICS       0       0       0       194         194.14       07964       HENRY COUNTY RADIOLOGY       2,009,339       2,009,339       194         194.15       07965       HENRY COUNTY ANESTHESI OLOGY       0       0       0						192.00
194.05       07955       OTHER NONREI MBURSABLE COSTS       260,476       0       260,476       194         194.06       07956       DR AFZAL       5,268       0       5,268       194         194.07       07957       PHI LLI PS HALL       14,691       0       14,691       194         194.08       07958       OB DRS       9,536       0       9,536       194         194.09       07959       THE WATERS       1,299,517       0       1,299,517       194         194.10       07960       CAMBRI DGE CI TY       433,955       0       433,955       194         194.11       07961       WELL BEING       680       0       680       194         194.12       07962       ACTI VATE HEALTH EMPLOYER CLINIC       77,191       0       77,191       194         194.13       07963       NEW CASTLE PEDI ATRICS       0       0       0       194         194.14       07964       HENRY COUNTY RADI OLOGY       2,009,339       0       2,009,339       194         194.16       07966       NEW CASTLE PEDI ATRICS       0       0       0       194         194.16       07966       NEW CASTLE I MMEDI CATE CARE & FAMI LY       0<		-	-		-	194.00
194.07       07957       PHILLIPS HALL       14,691       14,691       194         194.08       07958       0B DRS       9,536       0       9,536       194         194.09       07959       THE WATERS       1,299,517       0       1,299,517       194         194.10       07960       CAMBRI DGE CI TY       433,955       0       433,955       194         194.11       07960       KELL BEING       680       0       680       194         194.12       07962       ACTI VATE HEALTH EMPLOYER CLINIC       77,191       0       77,191       194         194.13       07963       NEW CASTLE PEDI ATRICS       0       0       0       194         194.14       07964       HENRY COUNTY RADIOLOGY       2,009,339       0       2,009,339       194         194.15       07965       HENRY COUNTY ANESTHESIOLOGY       0       0       0       194         194.16       07966       NEW CASTLE I MEDI CATE CARE & FAMILY       0       0       0       194         194.16       07966       NEW CASTLE I MEDI CATE CARE & FAMILY       0       0       0       200         200.00       Cross Foot Adj ustments       0       0       0 </td <td></td> <td>260, 476</td> <td>0</td> <td>260, 4</td> <td>76</td> <td>194.05</td>		260, 476	0	260, 4	76	194.05
194.08       07958       0B DRS       9,536       0       9,536       194         194.09       07959       THE WATERS       1,299,517       0       1,299,517       194         194.10       07960       CAMBRIDGE CITY       433,955       0       433,955       194         194.11       07961       WELL BEING       680       0       680       194         194.12       07962       ACTIVATE HEALTH EMPLOYER CLINIC       77,191       0       77,191       194         194.13       07963       NEW CASTLE PEDIATRICS       0       0       0       194         194.14       07964       HENRY COUNTY RADIOLOGY       2,009,339       0       2,009,339       194         194.15       07965       HENRY COUNTY ANESTHESIOLOGY       0       0       0       194         194.15       07966       NEW CASTLE I MMEDICATE CARE & FAMILY       0       0       0       194         194.16       07966       NEW CASTLE I MMEDICATE CARE & FAMILY       0       0       0       200         200.00       Cross Foot Adjustments       0       0       0       200       201       201         201.00       Negati ve Cost Centers       0	194. 06 07956 DR_AFZAL					194.06 194.07
194.09       07959       THE WATERS       1,299,517       0       1,299,517       194         194.10       07960       CAMBRI DGE CI TY       433,955       0       433,955       194         194.11       07961       WELL BEING       680       0       680       194         194.12       07962       ACTI VATE HEALTH EMPLOYER CLINIC       77,191       0       77,191       194         194.13       07963       NEW CASTLE PEDI ATRI CS       0       0       0       194         194.14       07964       HENRY COUNTY RADI OLOGY       2,009,339       0       2,009,339       194         194.15       07965       HENRY COUNTY ANESTHESI OLOGY       0       0       0       194         194.15       07966       NEW CASTLE I MEDI CATE CARE & FAMILY       0       0       0       194         194.15       07966       NEW CASTLE I MEDI CATE CARE & FAMILY       0       0       0       194         200.00       Cross Foot Adj ustments       0       0       0       200       201       0       201			-			194.07
194.11       07961       WELL BEING       680       0       680       194         194.12       07962       ACTIVATE HEALTH EMPLOYER CLINIC       77,191       0       77,191       194         194.13       07963       NEW CASTLE PEDIATRICS       0       0       0       194         194.14       07964       HENRY COUNTY RADIOLOGY       2,009,339       0       2,009,339       194         194.15       07965       HENRY COUNTY ANESTHESIOLOGY       0       0       194         194.16       07966       NEW CASTLE IMMEDICATE CARE & FAMILY       0       0       194         200.00       Cross Foot Adjustments       0       0       0       200       200         201.00       Negative Cost Centers       0       0       0       201       0       0       201	194.0907959 THE WATERS	1, 299, 517	0	1, 299, 5	17	194.09
194. 12       07962       ACTI VATE HEALTH EMPLOYER CLINIC       77, 191       0       77, 191       194         194. 13       07963       NEW CASTLE PEDI ATRICS       0       0       0       194         194. 14       07964       HENRY COUNTY RADI OLOGY       2, 009, 339       0       2, 009, 339       194         194. 15       07965       HENRY COUNTY ANESTHESI OLOGY       0       0       194         194. 16       07966       NEW CASTLE I IMEDI CATE CARE & FAMI LY       0       0       194         194. 16       07966       NEW CASTLE I IMEDI CATE CARE & FAMI LY       0       0       200       0       200         200. 00       Cross Foot Adj ustments       0       0       0       200       201       0       0       201						194. 10 194. 11
194.13       07963       NEW CASTLE PEDIATRICS       0       0       194         194.14       07964       HENRY COUNTY RADIOLOGY       2,009,339       0       2,009,339       194         194.15       07965       HENRY COUNTY ANESTHESIOLOGY       0       0       0       194         194.16       07966       NEW CASTLE I IMMEDICATE CARE & FAMILY       0       0       0       194         200.00       Cross Foot Adjustments       0       0       0       200       200       201       0       0       201			-	-		194.11
194.15       07965       HENRY COUNTY ANESTHESI OLOGY       0       0       194         194.16       07966       NEW CASTLE I MMEDI CATE CARE & FAMI LY       0       0       0       194         200.00       Cross Foot Adjustments       0       0       0       200       200         201.00       Negative Cost Centers       0       0       0       201	194. 13 07963 NEW CASTLE PEDIATRICS	0	0		0	194.13
194.16         07966         NEW CASTLE I MMEDI CATE CARE & FAMILY         0         0         194           200.00         Cross Foot Adjustments         0         0         0         200           201.00         Negative Cost Centers         0         0         0         201		2,009,339			39	194.14 104.15
200.00         Cross Foot Adjustments         0         0         200         200           201.00         Negative Cost Centers         0         0         0         201         201					0	194.15 194.16
	200.00 Cross Foot Adjustments	0	0		0	200.00
202.00   101AL (Sum TTHES TT8 (THOUGH 201)   103,034,856  0  103,034,856  202			-		0	201.00
	202.00   IUTAL (Sum TINES TIX ENFOUGH 201)	103, 034, 856	I U	η 103, 034, 8	וספ	202.00

Heal th	Fi na	nci a	al S	yste	ms	
ALLOCA	TION	OF (	CAPI	TAL	RELATED	COSTS

## HENRY COUNTY MEMORIAL HOSPITAL

Heal th	Financial Systems H	ENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
	TION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2020	Worksheet B Part II	pared:
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL REL NEW BLDG & FI XT	ATED COSTS NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00 4.00 5.00 7.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	33, 790 701, 696 1, 332, 618	2, 131 44, 257 84, 051	35, 921 745, 953 1, 416, 669	35, 921 4, 755 1, 071	1.00 2.00 4.00 5.00 7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY		66, 588 38, 676 140, 495	4, 031 4, 200 2, 439 8, 861	70, 788 41, 115 149, 356	0 392 218	8.00 9.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY		38, 384 77, 157 139, 230	2, 421 4, 866 8, 781	40, 805 82, 023 148, 011	209 1, 603 407	11.00
15.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	30, 404 45, 021		32, 322 47, 861	0 503	15.00 16.00
31.00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04300 NURSERY	0 0 0	571, 381 225, 808 59, 717	36, 038 14, 242 3, 766	607, 419 240, 050 63, 483	3, 861 1, 025 374	30.00 31.00 43.00
52.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	0	415, 976 30, 345 220, 377	26, 236 1, 914 13, 900	442, 212 32, 259 234, 277	3, 600 136 1, 261	1
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON		8, 525 10, 414	538 657	9, 063 11, 071	132 76 0	57.00 58.00 59.00
60.00	06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY		160, 796 0 40, 934	10, 142 0 2, 582	170, 938 0 43, 516	1, 407 0 581	60.00 60.01 65.00
67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	000000000000000000000000000000000000000	20, 379 3, 893 3, 757	1, 285 246 237	21, 664 4, 139 3, 994	1, 107 159 64	66.00
71.00 72.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0 0 0	0 0 0	0 0 0	0 0 0	127 0 0	69.00 71.00 72.00
76.00	07300 DRUGS CHARGED TO PATIENTS 03950 CARDIAC REHAB OUTPATIENT SERVICE COST CENTERS	0	0 13, 839	0 873	0 14, 712	0 79	73.00 76.00
88. 01 88. 02 91. 00	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 0	0 0 0 205, 701	0 0 0 12, 974	0 0 218, 675 0	2, 863 5, 466 209 1, 777	
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	826	101.00
114.00	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0	0 4, 635, 901	0 292, 395	0 4, 928, 296		113.00 114.00 116.00 118.00
	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	0	19, 640 0	1, 239 0	20, 879 0		190.00 192.00
194. 01 194. 05	07950 HOSPI TALI ST 07951 RENTAL 07955 OTHER NONREI MBURSABLE COSTS 07956 DR AFZAL		0 0 0	0 17, 943 0 0	0 17, 943 0 0	0	194.00 194.01 194.05 194.06
194. 07 194. 08 194. 09	07957 PHILLIPS HALL 07958 OB DRS 07959 THE WATERS 07960 CAMBRI DGE CITY		0 0 477, 523 0	0 0 30, 118 0	0 0 507, 641	0 0 176	194. 07 194. 08 194. 09 194. 10
194. 11 194. 12 194. 13	07961 WELL BEING 07962 ACTIVATE HEALTH EMPLOYER CLINIC 07963 NEW CASTLE PEDIATRICS			0	000000000000000000000000000000000000000	0 0 0	194. 11 194. 12 194. 13
194.15	07964 HENRY COUNTY RADIOLOGY 07965 HENRY COUNTY ANESTHESIOLOGY 07966 NEW CASTLE IMMEDICATE CARE & FAMILY Cross Foot Adjustments	0	0	0 0	0 0 0 0	0	194. 14 194. 15 194. 16 200. 00
201.00 202.00		0	0 5, 133, 064	0 341, 695	0 5, 474, 759		201. 00 202. 00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	HENRY COUNTY MEMO	RIAL HOSPITAL Provider CC	F	In Lie Period: From 01/01/2020 Fo 12/31/2020		pared:
Cost Center Description	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		DI ETARY	
	5.00	7.00	8.00	9.00	10.00	
GENERAL         SERVICE         COST         CENTERS           1.00         00100         NEW CAP         REL         COSTS-BLDG         FIXT           2.00         00200         NEW CAP         REL         COSTS-BLDG         FIXT           2.00         00200         NEW CAP         REL         COSTS-BLDG         FIXT           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           5.00         00500         ADMI NI STRATI VE         & GENERAL           7.00         00700         OPERATION OF         PLANT           8.00         00800         LAUNDRY         LI NEN         SERVICE           9.00         00900         HOUSEKEEPI NG         0         0           10.00         01100         CAFETERI A         0         3.00         01300         NURSI NG         ADMI NI STRATI ON           14.00         01400         CENTRAL         SERVICES         & SUPPLY	750, 708 44, 429 4, 496 9, 637 6, 095 3, 098 29, 256 11, 771	1, 462, 169 22, 438 13, 032 47, 341 12, 934 25, 999 46, 915	97, 72 4, 14 1, 11 ( (	7 68, 323 4 2, 224 5 679 5 351	206, 348 0 0 0	1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00
15.00 01500 PHARMACY	36, 293	10, 245	(		0	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	9, 903	15, 170	(	234	0	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000  ADULTS & PEDI ATRI CS           31. 00         03100  NTENSI VE CARE UNI T           43. 00         04300  NURSERY           ANCI LLARY SERVI CE COST CENTERS	58, 468 21, 729 7, 207	192, 533 76, 088 20, 122	19, 73 4, 44 1, 42	4, 483	170, 203 36, 145 0	30. 00 31. 00 43. 00
50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI ) 59. 00 05900 CARDI AC CATHETERI ZATI ON	49, 816 2, 697 28, 025 4, 948 2, 918 0	140, 168 10, 225 74, 259 2, 873 3, 509 0	17, 57( 515 7, 11 ( (	5 0 1 2,669 0 0 0 0	0 0 0 0 0 0	50.00 52.00 54.00 57.00 58.00 59.00
60.00         06000         LABORATORY           60.01         06001         BLOOD         LABORATORY           65.00         06500         RESPI RATORY         THERAPY           66.00         06600         PHYSI CAL         THERAPY           67.00         06700         OCCUPATI ONAL         THERAPY           68.00         06800         SPEECH         PATHOLOGY	51, 60 0 12, 378 20, 586 2, 744 1, 115	54, 182 0 18, 975 171, 748 1, 312 1, 266	124 (( 1, 883 266	4 808 0 0 0 1,674 3 5,209 9 737	0 0 0 0 0 0	60. 00 60. 01 65. 00 66. 00 67. 00 68. 00
69.0006900ELECTROCARDI OLOGY71.0007100MEDI CAL SUPPLI ES CHARGED TO PATI ENTS72.0007200I MPL.DEV.73.0007300DRUGS CHARGED TO PATI ENTS76.0003950CARDI AC REHAB	3, 597	0 0 0 4, 663		234 0 0 0 0 0 0	0 0 0 0 0	69.00 71.00 72.00 73.00 76.00
OUTPATIENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC	52, 253	103, 406	608	3 2, 130	0	88.00
88.01         08801         RURAL HEALTH CLINIC II           88.02         08802         RURAL HEALTH CLINIC III           91.00         09100         EMERGENCY           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)	91, 041 4, 611 39, 584	267, 290 19, 512 69, 313	293 ( 17, 505	3 6, 414 0 0	0	88. 01 88. 02 91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	15, 366	15,020	(	468	0	101.00
SPECIAL PURPOSE COST CENTERS	10,000	107 020				
113.00 11300 I NTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVI EW-SNF 116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LI NES 1 through 17 NONREI MBURSABLE COST CENTERS	9, 692 17) 703, 313	15, 013 1, 455, 551	( 76, 75(		0 206, 348	113.00 114.00 116.00 118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950 HOSPI TALI ST 194. 01 07951 RENTAL	182 17, 477 0 964	6, 618 0 0	(	0 0 0 0	0 0	190. 00 192. 00 194. 00 194. 01
194. 05 07955 OTHER NONREI MBURSABLE COSTS 194. 06 07956 DR AFZAL 194. 07 07957 PHI LLI PS HALL 194. 08 07958 OB DRS	1, 801 38 0	0 0 0 0	1, 825 ( 794 1, 31	5 0 0 0 4 433	0 0 0	194.05 194.06 194.07 194.08
194. 09 07959 THE WATERS 194. 10 07960 CAMBRIDGE CITY 194. 11 07961 WELL BEING 194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC	8, 565 3, 162 5 562	0 0 0 0	17, 042 ( (	2 0 0 0 0 0	0 0 0	194. 09 194. 10 194. 11 194. 12
194. 1307963NEW CASTLE PEDIATRICS194. 1407964HENRY COUNTY RADIOLOGY194. 1507965HENRY COUNTY ANESTHESIOLOGY194. 1607966NEW CASTLE IMMEDICATE CARE & FAMILY200. 00Cross Foot Adjustments201. 00Negative Cost Centers	0 14,639 0 0	0 0 0 0		0 0	0 0 0	194. 13 194. 14 194. 15 194. 16 200. 00 201. 00
202.00   TOTAL (sum lines 118 through 201)	750, 708	1, 462, 169	97, 722	68, 323	206, 348	202.00

	Financial Systems HE TION OF CAPITAL RELATED COSTS	NRY COUNTY MEN	Provider CC	N. 15-0030 P	In Lieu eriod:	u of Form CMS-2 Worksheet B	2552-10
ALLUCA	TION OF CAPITAL RELATED COSTS		FIOVIDEI CO	F	rom 01/01/2020	Part II	norod
				T	o 12/31/2020	Date/Time Pre 7/30/2021 9:1	<u>5 am</u>
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL	PHARMACY	MEDI CAL RECORDS &	
			ADMINISTRATIO N	SERVICES & SUPPLY		LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
1 00	GENERAL SERVICE COST CENTERS						1.00
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA	57, 725					11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	4, 390 1, 403		208, 741			13.00
	01500 PHARMACY	C		383			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 711	0	59	0	76, 441	16.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	10 770	2( 002	F 3/0		7 115	1 20 00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	10, 779 3, 320		5, 369 1, 843	-	7, 115 3, 222	
43.00	04300 NURSERY	1, 059		540		2, 457	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	8, 952		12, 529		13, 176	
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	385 4, 335		196 2, 894	0	0 9, 284	1
57.00	05700 CT SCAN	417		1, 676	-	4, 211	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	290		311	0	1, 117	
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	C	-	0	0	0	1
60.00 60.01	06000 LABORATORY 06001 BLOOD LABORATORY	6, 161 C		26, 294 0	0	13, 112 0	
65.00	06500 RESPIRATORY THERAPY	1, 992	-	597	0	766	
66.00	06600 PHYSI CAL THERAPY	4, 262		597	0	510	1
67.00	06700 OCCUPATI ONAL THERAPY	486		0	-	96	1
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	168 387		890	-	32 829	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C		40, 303		2,457	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	C		103, 468		3, 254	
73.00	07300 DRUGS CHARGED TO PATI ENTS 03950 CARDI AC REHAB	C		0		0	
76.00	OUTPATIENT SERVICE COST CENTERS	344	859	61	0	128	76.00
88.00	08800 RURAL HEALTH CLINIC	C	25, 030	893	0	542	88.00
88.01	08801 RURAL HEALTH CLINIC II	C		1, 579		1, 882	1
88.02	08802 RURAL HEALTH CLINIC III 09100 EMERGENCY	C	27.00	244	0	0	
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 884	14, 677	7, 369	0	11, 645	91.00
,2,00	OTHER REIMBURSABLE COST CENTERS				I		12100
101.00	10100 HOME HEALTH AGENCY	C	0	411	0	383	101.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		1				113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11600 HOSPI CE	C	-	235		223	116.00
118.00		57, 725	143, 622	208, 741	79, 817	76, 441	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	C		0			192.00
	07950 HOSPI TALI ST	C	0	0	0		194.00
	07951 RENTAL	C	0	0	0		194.01
	07955 OTHER NONREIMBURSABLE COSTS 07956 DR AFZAL	C	0	0	0		194.05 194.06
	07957 PHI LLI PS HALL	C	0	0	0		194.00
	07958 OB DRS	C	0	0			194.08
	07959 THE WATERS	C	0	0	-		194.09
	07960 CAMBRIDGE CITY 07961 WELL BEING		0	0	0		194.10 194.11
	07961 WELL BEING 07962 ACTIVATE HEALTH EMPLOYER CLINIC		0	0	0		194.11
	07963 NEW CASTLE PEDIATRICS	C	0	0	0		194.13
	07964 HENRY COUNTY RADI OLOGY	C	0	0	0		194.14
	07965 HENRY COUNTY ANESTHESI OLOGY	C	0	0	0		194.15
174.16	07966 NEW CASTLE IMMEDICATE CARE & FAMILY	C	0	0	0	0	194.16 200.00
	ULOSS FOOL AULUSTMENTS						
200.00 201.00 202.00	Negative Cost Centers	C 57, 725	0	0	0		201.00 202.00

LOCATI	ION OF CAPITAL RELATED COSTS		Provider CC	N: 15-0030	Period: From 01/01/2	Lieu of Form CMS-2552- Worksheet B 020 Part II
					To 12/31/2	
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		///30/2021 9. 15 am
C	ENERAL SERVICE COST CENTERS	24.00	25.00	26.00		
00         0           00         0           00         0           00         0           00         0           00         0           00         0           00         0           00         0           00         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0	ENERAL SERVICE COST CENTERS 10100 NEW CAP REL COSTS-BLDG & FIXT 10200 NEW CAP REL COSTS-MVBLE EQUIP 10400 EMPLOYEE BENEFITS DEPARTMENT 10500 ADMINISTRATIVE & GENERAL 10700 OPERATION OF PLANT 10800 LAUNDRY & LINEN SERVICE 10900 HOUSEKEEPING 11000 DIETARY 11100 CAFETERIA 11300 NURSING ADMINISTRATION 11400 CENTRAL SERVICES & SUPPLY 11500 PHARMACY 11600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS					1. 2. 4. 5. 7. 8. 9. 10. 11. 13. 14. 15. 16.
	3000 ADULTS & PEDIATRICS	1, 120, 674	0	1, 120, 6		30.
s. oo 🛛 o	13100 I NTENSI VE CARE UNI T 14300 NURSERY NCI LLARY SERVI CE COST CENTERS	400, 634 99, 638	0 0	400, 6 99, 6		31. 43.
0.00 0.00	5000 OPERATI NG ROOM 5200 DELI VERY ROOM & LABOR ROOM 5400 RADI OLOGY-DI AGNOSTI C 55700 CT SCAN	719, 038 47, 372 364, 115 23, 320	0 0 0 0	719, 0 47, 3 364, 1 23, 3	72 15 20	50. 52. 54. 57.
	15800 MAGNETI C RESONANCE I MAGI NG (MRI) 15900 CARDI AC CATHETERI ZATI ON	19, 292 0	0	19, 2	92 0	58. 59.
	6000 LABORATORY	324, 627	0	324, 6	-	60.
1		0	0	00.4	0	60. 65.
	6500 RESPI RATORY THERAPY 6600 PHYSI CAL THERAPY	80, 479 227, 566	0	80, 4 227, 5		66.
	6700 OCCUPATI ONAL THERAPY	9, 942	0	9,9		67.
	6800 SPEECH PATHOLOGY 6900 ELECTROCARDI OLOGY	6, 639 6, 064	0	6,6 6,0		68. 69.
. 00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	61, 420	0	61, 4	20	71.
	7200 I MPL. DEV. CHARGED TO PATIENT 7300 DRUGS CHARGED TO PATIENTS	154, 503 79, 817	0	154, 5 79, 8		72. 73.
o. 00 🛛 🖸	3950 CARDI AC REHAB	22, 364	0	22, 3		76.
	UTPATIENT SERVICE COST CENTERS	187, 725	0	187, 7	25	88.
	8801 RURAL HEALTH CLINIC II	413, 738	0	413, 7	38	88.
	18802 RURAL HEALTH CLINIC III 19100 EMERGENCY	26, 764 391, 884	0	26, 7 391, 8		88. 91.
2.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART) THER REIMBURSABLE COST CENTERS	371,004	0	371,0	04	92.
1.001	0100 HOME HEALTH AGENCY	32, 474	0	32, 4	74	101.
	PECIAL PURPOSE COST CENTERS 1300 INTEREST EXPENSE					113.
4.001	1400 UTILIZATION REVIEW-SNF					114.
6.001 8.00	1600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	25, 531 4, 845, 620	0	25, 5 4, 845, 6		116. 118.
N	ONREIMBURSABLE COST CENTERS	4, 043, 020		4,040,0	20	110.
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,831	0	27,8		190.
	9200 PHYSI CI ANS' PRI VATE OFFI CES 17950 HOSPI TALI ST	18, 287 0	0	18, 2	0	192. 194.
4. 01 0	7951 RENTAL	24, 748	0	24, 7	48	194.
	7955 OTHER NONREI MBURSABLE COSTS 17956 DR AFZAL	3, 626 38	0	3,6	26 38	194. 194.
	17956 DR AFZAL 17957 PHILLIPS HALL	38 1, 227	0	1, 2		194.
4. 08 0	7958 OB DRS	1, 311	0	1, 3	11	194.
	17959 THE WATERS 17960 CAMBRI DGE CI TY	533, 424	0	533, 4		194. 194.
	17960 CAMBRIDGE CITY 17961 WELL BEING	3, 312 5	0	3, 3	5	194. 194.
4. 120	7962 ACTIVATE HEALTH EMPLOYER CLINIC	562	0	5	62	194.
	17963 NEW CASTLE PEDIATRICS	0	0		0	194.
	17964 HENRY COUNTY RADI OLOGY 17965 HENRY COUNTY ANESTHESI OLOGY	14, 768 0	0	14, 7	68 0	194. 194.
	7966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	0		0	194.
0.00	Cross Foot Adjustments	0	0		0	200. 201.
1.00	Negative Cost Centers	0	0		0	

Health Financial Systems         H           COST ALLOCATION - STATISTICAL BASIS         H	ENRY COUNTY MEMO	DRIAL HOSPITAL Provider C	CN: 15-0030 P	Period:	u of Form CMS-: Worksheet B-1	
				rom 01/01/2020 o 12/31/2020		
	CAPI TAL REL	ATED COSTS			1773072021 3.1	
Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS	262 714		[			1 00
1.00       00100       NEW CAP REL COSTS-BLDG & FIXT         2.00       00200       NEW CAP REL COSTS-MVBLE EQUIP         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         5.00       00500       ADMINISTRATIVE & GENERAL         7.00       00700       OPERATION OF PLANT         8.00       00800       LAUNDRY & LINEN SERVICE         9.00       00900       HOUSEKEEPING         10.00       01000       DI ETARY         11.00       01100       CAFETERIA         13.00       01300       NURSI NG ADMINISTRATION         14.00       01400       CENTRAL SERVICES & SUPPLY         15.00       01500       PHARMACY         16.00       01600       MEDICAL RECORDS & LIBRARY	263, 714 1, 736 36, 050 68, 464 3, 421 1, 987 7, 218 1, 972 3, 964 7, 153 1, 562 2, 313	278, 330 1, 736 36, 050 68, 464 3, 421 1, 987 7, 218 1, 972 3, 964 7, 153 1, 562 2, 313	50, 201, 612 6, 641, 642 1, 495, 248 547, 711 303, 903 291, 470 2, 239, 220 568, 369	-16, 937, 408 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 095, 666 515, 612 1, 105, 255 699, 041 355, 373 3, 355, 440 1, 350, 048 4, 162, 486	11.00 13.00 14.00 15.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	29, 355	29, 355	5, 393, 123	0	6 70E 74E	30.00
31. 00 03100 INTENSIVE CARE UNIT	29, 355	29, 355 11, 601				
43.00 04300 NURSERY	3, 068	3, 068	522, 538	0	826, 540	43.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM	21, 371	21, 371	5, 027, 388	0	5, 713, 467	50.00
52.00         05200         DELIVERY ROOM & LABOR ROOM           54.00         05400         RADI OLOGY-DI AGNOSTI C           57.00         05700         CT SCAN           58.00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)           59.00         05900         CARDI AC CATHETERI ZATI ON           60.00         06000         LABORATORY	1, 559 11, 322 438 535 0 8, 261	1, 559 1, 559 11, 322 438 535 0 8, 261	189, 759 1, 760, 606 184, 384 106, 119		309, 362 3, 214, 248 567, 446 334, 708 0	52.00 54.00 57.00 58.00 59.00
60. 01 06001 BLOOD LABORATORY	0,201	0, 201				60.01
65. 00 06500 RESPIRATORY THERAPY	2, 103	2, 103				
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	1, 047 200	1, 047 200			2, 361, 069 314, 738	
68. 00 06800 SPEECH PATHOLOGY	193	193			127, 849	
69.00 06900 ELECTROCARDI OLOGY	0	0				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76. 00 03950 CARDI AC REHAB	711	711	110, 362	0	174, 147	76.00
0UTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC			2 000 222	0	F 002 012	
88.00  08800  RURAL HEALTH CLINIC 88.01  08801  RURAL HEALTH CLINIC	0	0 0				
88.02 08802 RURAL HEALTH CLINIC III	0	0				1
91.00 09100 EMERGENCY	10, 568	10, 568	2, 482, 377	0	4, 539, 917	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101. 00 10100 HOME HEALTH AGENCY	0	0	1, 153, 854	0	1, 762, 326	101.00
SPECIAL PURPOSE COST CENTERS	1 1		1	1	1	
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF						113.00 114.00
116. 00 11600 HOSPI CE	0	0	513, 525	0	1, 111, 553	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	238, 172	238, 172	48, 435, 229	-16, 937, 408	80, 661, 462	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	1,009	C	0	20, 879	100 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1,009	1,009				
194. 00 07950 HOSPI TALI ST	0	0	C	0	0	194.00
194. 01 07951 RENTAL	0	14, 616		-		
194. 05 07955 OTHER NONREI MBURSABLE COSTS 194. 06 07956 DR AFZAL	0	0		0 0		194.05 194.06
194. 07 07957 PHI LLI PS HALL	0	0		-		194.07
194.08 07958 OB DRS	0	0	C	0		194.08
194. 09 07959 THE WATERS	24, 533	24, 533			982, 339	
194. 10 07960  CAMBRI DGE_CI TY 194. 11 07961  WELL_BEI NG		0	208, 877			194.10 194.11
194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC	0	0		-		
194. 13 07963 NEW CASTLE PEDIATRICS	0	0	0	-	0	194.13
194. 14 07964 HENRY COUNTY RADIOLOGY	0	0	180, 847	0		
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY 194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	0				194. 15 194. 16
200.00 Cross Foot Adjustments		0				200.00
201.00 Negative Cost Centers						201.00

Heal th I	- Financial Systems HE	HENRY COUNTY MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
COST AL	LOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2020	Worksheet B-1	
					To 12/31/2020		
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE		ADMI NI STRATI V	
		FI XT (SQUARE	EQUI P (SQUARE	BENEFI TS DEPARTMENT	n	E & GENERAL (ACCUM.	
		FEET)	FEET)	(GROSS SALARI ES)		COST)	
		1.00	2.00	4.00	5A	5.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	5, 133, 064	341, 695	16, 339, 920	b	16, 937, 408	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	19. 464511	1. 227661	0. 325486	ò	0. 196724	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			35, 92		750, 708	204.00
205.00	Unit cost multiplier (Wkst. B, Part			0.000716	5	0. 008719	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	HENRY COUNTY MEM	ORIAL HOSPITAL Provider C	CN: 15-0030 P	eriod:	u of Form CMS-2 Worksheet B-1	
				rom 01/01/2020 o 12/31/2020	Date/Time Pre 7/30/2021 9:1	
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERI A (FTE' S)	
	7.00	8.00	9.00	10.00	11.00	
GENERAL         SERVICE         COST         CENTERS           1.00         00100         NEW CAP         REL         COSTS-BLDG & FIXT           2.00         00200         NEW CAP         REL         COSTS-BLDG & FIXT           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           5.00         00500         ADMINISTRATIVE         & GENERAL           7.00         00700         OPERATION OF PLANT           8.00         00800         LAUNDRY         LINEN SERVICE           9.00         00900         HOUSEKEEPING         001000           10.00         01000         DETARY         11.00           11.00         01100         CAFETERIA         3.00         01300           13.00         01300         NURSI NG         ADMINISTRATION           14.00         01400         CENTRAL         SERVICES         & SUPPLY           15.00         01500         PHARMACY         10.00         01600         MEDICAL         RECORDS         LIBRARY           1NPATI ENT         NOTIVE         000000         RECORDS         LIBRARY	222, 933 3, 421 1, 987 7, 218 1, 972 3, 964 7, 153 1, 562 2, 313	705, 361 29, 931 8, 039 0 0 0 0 0 0	58 30 20 49 20	000000000000000000000000000000000000000	627, 090 47, 689 15, 244 0 29, 449	13.00 14.00 15.00 16.00
30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         INTENSI VE CARE UNI T           43. 00         04300         NURSERY           ANCI LLARY SERVI CE COST CENTERS	29, 355 11, 601 3, 068	142, 471 32, 100 10, 299	1, 564 383 28	1, 391	117, 082 36, 069 11, 501	30.00 31.00 43.00
50. 00         05000         OPERATING ROOM           52. 00         05200         DELIVERY ROOM & LABOR ROOM           54. 00         05400         RADIOLOGY-DIAGNOSTIC           57. 00         05700         CT SCAN           58. 00         05800         MAGNETIC RESONANCE IMAGING (MRI)           59. 00         05900         CARDIAC CATHETERIZATION           60. 01         06000         LABORATORY           60. 01         06000         BLOOD LABORATORY           65. 00         06500         RESPIRATORY THERAPY           66. 00         06600         PHYSICAL THERAPY           67. 00         06700         OCUPATIONAL THERAPY           68. 00         06800         SPEECH PATHOLOGY           69. 00         06900         ELECTROCARDIOLOGY           71. 00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS           72. 00         07200         IMPL.         DEV. CHARGED TO PATIENT           73. 00         07300         DRUGS CHARGED TO PATIENTS           76. 00         03950         CARDIAC REHAB	21, 371 1, 559 11, 322 438 535 0 8, 261 0 2, 893 26, 186 200 193 0 0 0 0 0 0 0 0 0	126, 819 3, 719 51, 328 0 0 892 0 13, 594 1, 940 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 228 0 0 0 0 69 0 143		97, 253 4, 177 47, 091 4, 529 3, 152 0 66, 934 0 21, 643 46, 295 5, 283 1, 829 4, 208 0 0 0 0 0 3, 740	69.00 71.00 72.00 73.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC           88.01         08801         RURAL HEALTH CLINIC           88.02         08802         RURAL HEALTH CLINIC II           91.00         09100         EMERGENCY           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)	15, 766 40, 753 2, 975 10, 568	2, 114 0	182 548 0 466	0 0 0 0	0 0 63, 922	88.00 88.01 88.02 91.00 92.00
OTHER REIMBURSABLE COST CENTERS	2, 290	0	40	0	0	101.00
SPECIAL PURPOSE COST CENTERS           113.00         11300         INTEREST EXPENSE           114.00         11400         UTI LI ZATI ON REVIEW-SNF           116.00         11600         HOSPICE           118.00         SUBTOTALS (SUM OF LINES 1 through 117           NONREI MBURSABLE COST CENTERS	2, 289 7) 221, 924		0 5, 288	0 7, 941	0 627, 090	113.00 114.00 116.00 118.00
190.00       19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN         192.00       19200       PHYSICIANS' PRIVATE OFFICES         194.00       07950       HOSPITALIST         194.01       07951       RENTAL         194.06       07955       OTHER NONREIMBURSABLE COSTS         194.06       07956       DR AFZAL         194.06       07957       PHILLIPS HALL         194.07       07957       PHILLIPS HALL         194.08       07958       OB DRS         194.09       07959       THE WATERS         194.10       07960       CAMBRIDGE CITY         194.11       07961       WELL BEING         194.12       07962       ACTIVATE HEALTH EMPLOYER CLINIC         194.13       07963       NEW CASTLE PEDIATRICS         194.14       07964       HENRY COUNTY ANESTHESIOLOGY         194.15       07966       NEW CASTLE IMEDICATE CARE & FAMILY         200.00       Cross Foot Adjustments       201.00         Negative Cost Centers       202.00       Cost to be allocated (per Wkst. B,	1, 009 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 13, 172 0 5, 728 9, 465 123, 010 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 499 0 0 37 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	190. 00 192. 00 194. 01 194. 05 194. 05 194. 06 194. 07 194. 08 194. 09 194. 10 194. 11 194. 12 194. 13 194. 14 194. 15 194. 16 200. 00 201. 00 202. 00
203.00 Part I) Unit cost multiplier (Wkst. B, Part I	27. 353985	1. 007460	241. 081206	136. 998363	0. 786503	203. 00

Health F	inancial Systems H	ENRY COUNTY MEN	IORIAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provider C	CN: 15-0030	Period: From 01/01/2020	Worksheet B-1		
					To 12/31/2020	Date/Time Pre 7/30/2021 9:1		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI N	G DI ETARY	CAFETERI A		
		PLANT	LINEN SERVICE	(HOURS OF	(PATI ENT	(FTE'S)		
		(SQUARE	(POUNDS OF	SERVICE)	DAYS)			
		FEET)	LAUNDRY)					
		7.00	8.00	9.00	10.00	11.00		
204.00	Cost to be allocated (per Wkst. B,	1, 462, 169	97, 722	68, 3	23 206, 348	57, 725	204.00	
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part	6. 558782	0. 138542	11. 7051	25. 985140	0. 092052	205.00	
	11)							
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)							

	Financial Systems HE LLOCATION - STATISTICAL BASIS	ENRY COUNTY MEM	Provider CC	CN: 15-0030	Peri od:	u of Form CMS-2552-1 Worksheet B-1
					From 01/01/2020 To 12/31/2020	
	Cost Center Description	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	
2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	625, 499				1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00
15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0 0 0	11, 056, 007 20, 278 3, 132	100	2, 396	14.00 15.00 16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	117, 082 36, 069	284, 387 97, 611	(	223 0 101	30. 00 31. 00
	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	11, 501	28, 607	(	D 77	43.00
50.00 52.00 54.00 57.00	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	97, 253 4, 177 0 0	663, 632 10, 389 153, 260 88, 760 16, 495	(	0 413 0 0 0 291 0 132 0 35	50.00 52.00 54.00 57.00 58.00
59.00 60.00 60.01 65.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 0 0	0 1, 392, 675 0 31, 633 31, 597	(	0 0 0 411 0 0 0 24 0 16	59.00 60.00 60.0 65.00 65.00 66.00
67.00 68.00 69.00 71.00	06700 OCCUPATI ONL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENT	0 0 0 0	0 0 47, 141 2, 134, 707 5, 480, 052		5 3 5 3 7 1 7 26 7 77 0 102	67. 00 68. 00 69. 00 71. 00 72. 00
73.00 76.00	07300 DRUGS CHARGED TO PATI ENTS 03950 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS	0 3, 740	0 3, 239	100		73.00
	08800 RURAL HEALTH CLINIC	109, 010	47, 296	(	0 17	88.00
88. 01 88. 02	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	173, 215 9, 530	83, 647 12, 912		59 5000	88. 0 <sup>-</sup> 88. 02
92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	63, 922	390, 333	(	365	91.00
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	21, 782	(	0 12	101.00
113.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE					113.00
116. 00 118. 00	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 625, 499	12, 442 11, 056, 007	( 10	D 7 D 2, 396	114. 00 116. 00 118. 00
190.00 192.00 194.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICLANS' PRIVATE OFFICES 07950 HOSPITALIST 07951 RENTAL	000000000000000000000000000000000000000	0 0 0	(		190.00 192.00 194.00 194.0
194. 05 194. 06	07955 OTHER NONREI MBURSABLE COSTS 07956 DR AFZAL 07957 PHI LLI PS HALL	0	0 0 0 0			194.0 194.0 194.0 194.0
194. 09 194. 10	07958 OB DRS 07959 THE WATERS 07960 CAMBRI DGE CI TY	000000000000000000000000000000000000000	0 0 0	(		194. 08 194. 09 194. 10
194. 12 194. 13	07961 WELL BEING 07962 ACTIVATE HEALTH EMPLOYER CLINIC 07963 NEW CASTLE PEDIATRICS 07964 HENRY COUNTY RADIOLOGY	000000000000000000000000000000000000000	0 0 0 0		0 0 0 0 0 0 0	194. 1 194. 1 194. 1 194. 1 194. 1
194. 15 194. 16 200. 00	07965 HENRY COUNTY ANESTHESIOLOGY 07966 NEW CASTLE IMMEDICATE CARE & FAMILY Cross Foot Adjustments	0	0 0	(	0 0 0 0	194. 15 194. 16 200. 00
201.00 202.00	5	4, 168, 707 6. 664610	1, 828, 109	5, 039, 24 50, 392. 40000		201.00 202.00 203.00

Health Financial Systems	HENRY COUNTY MEM	ORIAL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1		
				From 01/01/2020 To 12/31/2020			
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL			
	ADMI NI STRATI O	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY			
	(DI RECT	(COSTED	KEQ013. )	(TIME			
	NRSING HRS)	REQUIS.)		SPENT)			
	13.00	14.00	15.00	16.00			
204.00 Cost to be allocated (per Wkst. B, Part II)	143, 622	208, 741	79, 81	7 76, 441		204.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 229612	0. 018880	798. 17000	0 31.903589		205.00	
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)	t					206.00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	

		INTAL HUSTTAL				2332-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/30/2021 9:1	pared: 5 am
		Title	XVIII	Hospi tal	PPS	
				Costs	115	
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	11, 300, 310		11, 300, 31	0 0	11, 300, 310	30.00
31. 00 03100 I NTENSI VE CARE UNI T	3, 961, 032		3, 961, 03		3, 961, 032	
43. 00 04300 NURSERY	1, 227, 246		1, 227, 24		1, 227, 246	
ANCI LLARY SERVICE COST CENTERS	1,22,7,210	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u> </u>	1,227,210	10100
50. 00 05000 OPERATING ROOM	8, 813, 159		8, 813, 15	9 0	8, 813, 159	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	449, 454		449, 45		449, 454	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 501, 558		4, 501, 55		4, 501, 558	
57. 00 05700 CT SCAN	789, 235		789, 23		789, 235	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	441, 589		441, 58		441, 589	
59. 00 05900 CARDI AC CATHETERI ZATI ON	441, 309		441, 50	0 0	441, 589	
60. 00 06000 LABORATORY	7, 857, 870		7, 857, 87		7, 857, 870	
60. 01 06001 BLOOD LABORATORY	7,007,070		1,001,01	0 0	7, 657, 870	1
65. 00 06500 RESPIRATORY THERAPY	1, 849, 277	0	1, 849, 27		-	65.00
					1, 849, 277	
	3, 714, 141				3, 714, 141	
	405, 240				405, 240	
68. 00 06800 SPEECH PATHOLOGY	160, 324		100, 02		160, 324	
69. 00 06900 ELECTROCARDI OLOGY	525, 329		525, 32		525, 329	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 960, 808		2, 960, 80		2, 960, 808	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	7, 526, 005		7, 526, 00		7, 526, 005	
73.00 07300 DRUGS CHARGED TO PATIENTS	5,039,240		5, 039, 24		5,039,240	
76.00 03950 CARDI AC REHAB	258, 681		258, 68	1 0	258, 681	76.00
OUTPATIENT SERVICE COST CENTERS				-		
88.00 08800 RURAL HEALTH CLINIC	8, 396, 163		8, 396, 16		8, 396, 163	
88.01 08801 RURAL HEALTH CLINIC II	14, 945, 591		14, 945, 59		14, 945, 591	
88.02 08802 RURAL HEALTH CLINIC III	779, 843		779, 84		779, 843	
91.00 09100 EMERGENCY	6, 723, 625		6, 723, 62		6, 756, 683	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 378, 128		1, 378, 12	8	1, 378, 128	92.00
OTHER REIMBURSABLE COST CENTERS		•				
101.0010100 HOME HEALTH AGENCY	2, 192, 171		2, 192, 17	1	2, 192, 171	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
116.00 11600 HOSPI CE	1, 399, 131		1, 399, 13	1	1, 399, 131	116.00
200.00 Subtotal (see instructions)	97, 595, 150	0	97, 595, 15	0 33, 058	97, 628, 208	200.00
201.00 Less Observation Beds	1, 378, 128		1, 378, 12	8	1, 378, 128	201.00
202.00 Total (see instructions)	96, 217, 022	0	96, 217, 02	2 33, 058	96, 250, 080	202.00
		•				

		ENRY COUNTY MEMO				u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CC	:N: 15-0030	Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/30/2021 9:1	epared: 5 am
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	•	6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
		(	7.00			Ratio	
	UNDATIONT POUTINE CEDVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	14 707 (05	I	14 707 //			1 20 00
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	14, 787, 695		14, 787, 69			30.00
31.00 43.00	04300 NURSERY	6, 003, 396 2, 094, 430		6, 003, 39 2, 094, 43			31.00 43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	2,094,430		2,094,43	30		43.00
50.00	05000 OPERATING ROOM	8, 747, 364	25, 816, 401	34, 563, 76	0, 254983	0. 000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 199, 627	1, 186, 304	2, 385, 93		0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 850, 558	16, 594, 756	18, 445, 3		0.000000	
57.00	05700 CT SCAN	2, 810, 847	26, 099, 550	28, 910, 39		0.000000	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	505, 957	7, 361, 647	7, 867, 60		0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	505, 757	7, 301, 047	7,007,00	0 0.000000	0. 000000	1
60.00	06000 LABORATORY	9, 447, 830	32, 461, 998	41, 909, 82		0.000000	
60.00	06001 BLOOD LABORATORY	, 447, 030	32,401,770	41, 707, 02	0 0. 000000	0.000000	60.01
65.00	06500 RESPI RATORY THERAPY	3, 160, 294	2, 237, 493	5, 397, 78		0.000000	
66.00	06600 PHYSI CAL THERAPY	742, 421	2, 237, 473	3, 677, 47		0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	233, 617	467, 769	701, 38		0.000000	
68.00	06800 SPEECH PATHOLOGY	93, 197	144, 468	237,66		0.000000	
69.00	06900 ELECTROCARDI OLOGY	1, 490, 368	4, 378, 192	5, 868, 56		0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 117, 959	12, 282, 405	17, 400, 36		0, 000000	
	07200 IMPL. DEV. CHARGED TO PATIENT	12,061,378	11, 174, 044	23, 235, 42		0.000000	
	07300 DRUGS CHARGED TO PATIENTS	5, 787, 271	5, 942, 088	11, 729, 35		0.000000	
	03950 CARDI AC REHAB	21, 242	905, 388	926, 63		0.000000	
	OUTPATIENT SERVICE COST CENTERS		· · · ·	· ·			
88.00	08800 RURAL HEALTH CLINIC	0	3, 757, 687	3, 757, 68	37		88.00
88.01	08801 RURAL HEALTH CLINIC II	0	13, 456, 386	13, 456, 38	36		88.01
88.02	08802 RURAL HEALTH CLINIC III	0	443, 199	443, 19	99		88.02
91.00	09100 EMERGENCY	6, 087, 953	42, 184, 311	48, 272, 26	0. 139285	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	362, 953	1, 404, 211	1, 767, 16	0. 779853	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	2, 629, 893	2, 629, 89	93		101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF						114.00
	11600 HOSPI CE	0	1, 533, 072	1, 533, 07			116.00
200.00		82, 606, 357	215, 396, 315	298, 002, 67	12		200.00
201.00							201.00
202.00	Total (see instructions)	82, 606, 357	215, 396, 315	298, 002, 67	72		202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0030	Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pr 7/30/2021 9:	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDIATRICS					30.0
1.00 03100 INTENSIVE CARE UNIT					31. (
3. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					
0.00 05000 OPERATING ROOM	0. 254983				50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 188377				52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 244049				54.0
7.00 05700 CT SCAN	0. 027299				57.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 056128				58.
9. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.
0. 00 06000 LABORATORY	0. 187495				60.
0.01 06001 BLOOD LABORATORY	0. 000000				60.
5. 00 06500 RESPI RATORY THERAPY	0.342599				65.
6. 00 06600 PHYSI CAL THERAPY	1.009971				66.
7.00 06700 OCCUPATI ONAL THERAPY	0. 577770				67.
8.00 06800 SPEECH PATHOLOGY	0. 674580				68.
9. 00 06900 ELECTROCARDI OLOGY	0. 089516				69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 170158				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 323902				72.
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 429626				73.
6. 00 03950 CARDI AC REHAB	0. 279163				76.
OUTPATIENT SERVICE COST CENTERS					
8.00 08800 RURAL HEALTH CLINIC					88.
8.01 08801 RURAL HEALTH CLINIC II					88.
8.02 08802 RURAL HEALTH CLINIC III					88.
1.00 09100 EMERGENCY	0. 139970				91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 779853				92.
OTHER REIMBURSABLE COST CENTERS					
01.00 10100 HOME HEALTH AGENCY					1101.
SPECIAL PURPOSE COST CENTERS					
13. 00 11300 I NTEREST EXPENSE					113.
14.00 11400 UTI LI ZATI ON REVI EW-SNF					114.
16. 00 11600 HOSPI CE					116.
00.00 Subtotal (see instructions)					200.
01.00 Less Observation Beds					201.
02.00 Total (see instructions)					202.

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COMPLIT		0F	PATIO	OF	27200	ΤO	C

### HENRY COUNTY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	pared:
			e XIX	Hospi tal	Cost	
	T I I O I I	<b>T</b> I	Talah Qaala	Costs	Tabab Quala	
Cost Center Description	Total Cost (from Wkst.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	B, Part I,					
	<u>col. 26)</u>	0.00	0.00	1.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	11 000 010		11 000 01		11 000 010	
30. 00 03000 ADULTS & PEDI ATRI CS	11, 300, 310		11, 300, 31			
31. 00 03100 I NTENSI VE CARE UNI T	3, 961, 032		3, 961, 03		3, 961, 032	
43. 00 04300 NURSERY	1, 227, 246		1, 227, 24	6 0	1, 227, 246	43.00
ANCI LLARY SERVI CE COST CENTERS	0.010.150		0.010.15		0.010.150	
50.00 05000 OPERATING ROOM	8, 813, 159		8, 813, 15			
52.00 05200 DELIVERY ROOM & LABOR ROOM	449, 454		449, 45		449, 454	
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 501, 558		4, 501, 55		4, 501, 558	
57.00 05700 CT SCAN	789, 235		789, 23		789, 235	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	441, 589		441, 58		441, 589	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	7,857,870		7, 857, 87		7, 857, 870	60.00
60.01 06001 BLOOD LABORATORY	0			0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	1, 849, 277		1, 849, 27	7 0	1, 849, 277	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 714, 141	0	3, 714, 14	1 0	3, 714, 141	66.00
67.00 06700 OCCUPATI ONAL THERAPY	405, 240	0	405, 24	0 0	405, 240	67.00
68.00 06800 SPEECH PATHOLOGY	160, 324	0	160, 32	24 0	160, 324	68.00
69. 00 06900 ELECTROCARDI OLOGY	525, 329		525, 32	29 0	525, 329	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 960, 808		2, 960, 80	0 8	2, 960, 808	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	7, 526, 005		7, 526, 00	05 0	7, 526, 005	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 039, 240		5, 039, 24	0 0	5, 039, 240	73.00
76. 00 03950 CARDI AC REHAB	258, 681		258, 68	31 0	258, 681	76.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	8, 396, 163		8, 396, 16	03 0	8, 396, 163	88.00
88.01 08801 RURAL HEALTH CLINIC II	14, 945, 591		14, 945, 59	01 0	14, 945, 591	88.01
88.02 08802 RURAL HEALTH CLINIC III	779, 843		779, 84	3 0	779, 843	88.02
91. 00 09100 EMERGENCY	6, 723, 625		6, 723, 62	33, 058	6, 756, 683	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 378, 128		1, 378, 12		1, 378, 128	
OTHER REIMBURSABLE COST CENTERS		1				
101.00 10100 HOME HEALTH AGENCY	2, 192, 171		2, 192, 17	/1	2, 192, 171	101.00
SPECIAL PURPOSE COST CENTERS		1				
113.00 11300 INTEREST EXPENSE	1					113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
116. 00 11600 HOSPI CE	1, 399, 131		1, 399, 13	31	1, 399, 131	
200.00 Subtotal (see instructions)	97, 595, 150					
201.00 Less Observation Beds	1, 378, 128		1, 378, 12		1, 378, 128	
202.00 Total (see instructions)	96, 217, 022					
	, , , , , , , , , , , , , , , , , , , ,		, , , , , , , , , , , , , , , , , , , ,	- 000,000	,0,200,000	1-02.00

Heal th	Financial Systems HE	ENRY COUNTY MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/30/2021 9:1	pared: 5 am
		-	Title	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	•	6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
		(	7.00			Ratio	
	INDATIONE DOUTINE CEDVILOE COOT CENTERS	6.00	7.00	8.00	9.00	10.00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	14 707 (05		14 707 / (			
30.00 31.00	03100 INTENSIVE CARE UNIT	14, 787, 695 6, 003, 396		14, 787, 69 6, 003, 39			30.00 31.00
43.00	04300 NURSERY	8,003,398 2,094,430		2, 094, 43			43.00
43.00	ANCI LLARY SERVICE COST CENTERS	2,094,430		2,094,43	50		43.00
50.00	05000 OPERATING ROOM	8, 747, 364	25, 816, 401	34, 563, 76	0. 254983	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 199, 627	1, 186, 304	2, 385, 93		0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 850, 558	16, 594, 756	18, 445, 31		0.000000	54.00
57.00	05700 CT SCAN	2, 810, 847	26, 099, 550	28, 910, 39		0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	505, 957	7, 361, 647	7, 867, 60		0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	7, 301, 047	7,007,00	0 0.000000	0.000000	59.00
60.00	06000 LABORATORY	9, 447, 830	32, 461, 998	41, 909, 82		0.000000	60.00
60.00	06001 BLOOD LABORATORY	, 44, , 030	32,401,770	41, 707, 02	0 0. 000000	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	3, 160, 294	2, 237, 493	5, 397, 78		0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	742, 421	2, 935, 053	3, 677, 47		0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	233, 617	467, 769	701, 38		0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	93, 197	144, 468	237,66		0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	1, 490, 368	4, 378, 192	5, 868, 56		0, 000000	69.00
		5, 117, 959	12, 282, 405	17, 400, 36		0.000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	12,061,378	11, 174, 044	23, 235, 42		0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 787, 271	5, 942, 088	11, 729, 35		0.000000	73.00
76.00	03950 CARDI AC REHAB	21, 242	905, 388	926, 63		0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS	· · ·		· · · ·			
88.00	08800 RURAL HEALTH CLINIC	0	3, 757, 687	3, 757, 68	2. 234397	0.00000	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	13, 456, 386	13, 456, 38	1. 110669	0.000000	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	443, 199	443, 19	1. 759578	0.000000	88.02
91.00	09100 EMERGENCY	6, 087, 953	42, 184, 311	48, 272, 26	0. 139285	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	362, 953	1, 404, 211	1, 767, 16	0. 779853	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	2, 629, 893	2, 629, 89	3		101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11600 HOSPI CE	0	1, 533, 072	1, 533, 07			116.00
200.00		82, 606, 357	215, 396, 315	298, 002, 67	2		200.00
201.00							201.00
202.00	Total (see instructions)	82, 606, 357	215, 396, 315	298, 002, 67	2		202.00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0030	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pr 7/30/2021 9:	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient		· · · · ·		
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDI ATRI CS					30.0
	03100 I NTENSI VE CARE UNI T					31.0
	04300 NURSERY					
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0. 000000				50.
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.
	05700 CT SCAN	0. 000000				57.
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.
9.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.
0.00	06000 LABORATORY	0. 000000				60.
0. 01	06001 BLOOD LABORATORY	0. 000000				60.
5.00	06500 RESPI RATORY THERAPY	0. 000000				65.
6.00	06600 PHYSI CAL THERAPY	0. 000000				66.
7.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.
8.00	06800 SPEECH PATHOLOGY	0. 000000				68.
9.00	06900 ELECTROCARDI OLOGY	0. 000000				69.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.
2.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.
3.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.
6.00	03950 CARDI AC REHAB	0. 000000				76.
Ī	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				
38.00	08800 RURAL HEALTH CLINIC	0. 000000				88.
8. 01	08801 RURAL HEALTH CLINIC II	0. 000000				88.
8. 02	08802 RURAL HEALTH CLINIC III	0. 000000				88.
	09100 EMERGENCY	0. 000000				91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.
Ī	OTHER REIMBURSABLE COST CENTERS	· · ·				
01.00	10100 HOME HEALTH AGENCY					101.
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					113.
	11400 UTI LI ZATI ON REVI EW-SNF					114.
	11600 HOSPI CE					116.
00.00	Subtotal (see instructions)					200.
201.00	Less Observation Beds					201.
202.00	Total (see instructions)					202.

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Health Financial Systems H	NRY COUNTY MEMORIAL HOSPITAL			In Lie	2552-10	
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	CN: 15-0030	Period:	Worksheet D	
				From 01/01/2020		
				To 12/31/2020	Date/Time Pre 7/30/2021 9:1	epared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
COST Center Description	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	Aujustillent	Related Cost		col. 4)	
	B, Part II,		(col. 1 -	•	COI. 4)	
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30. 00 ADULTS & PEDIATRICS	1, 120, 674	0	1, 120, 67	7, 306	153.39	30.00
31. 00 I NTENSI VE CARE UNI T	400, 634		400, 63			•
43. 00 NURSERY	99, 638		99, 63			•
200.00 Total (lines 30 through 199)	1, 620, 946		1, 620, 94			200.00
Cost Center Description	Inpati ent	Inpati ent	1102011	,,200		200100
	Program days	Program				
	l'rogram dayo	Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 568	393, 906				30.00
31.00 INTENSIVE CARE UNIT	623	179, 436				31.00
43.00 NURSERY	0	0	1			43.00
200.00 Total (lines 30 through 199)	3, 191	573, 342				200.00

Health Financial Systems Hi	ENRY COUNTY MEN	IORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2020 To 12/31/2020		
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)	-		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	719, 038	34, 563, 765	0. 02080	3 3, 262, 707	67, 874	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	47, 372	2, 385, 931	0. 01985	5 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	364, 115	18, 445, 314	0. 01974	0 1, 007, 009	19, 878	54.00
57.00 05700 CT SCAN	23, 320	28, 910, 397	0. 00080	7 1, 220, 394	985	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	19, 292	7, 867, 604	0. 00245	2 166, 416	408	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000	0 0	0	59.00
60. 00 06000 LABORATORY	324, 627	41, 909, 828	0. 00774	6 4, 243, 209	32, 868	60.00
60.01 06001 BLOOD LABORATORY	0	0	0. 00000	0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	80, 479	5, 397, 787	0. 01491	0 1, 084, 653	16, 172	65.00
66.00 06600 PHYSI CAL THERAPY	227, 566	3, 677, 474	0. 06188	1 380, 372	23, 538	66.00
67.00 06700 OCCUPATI ONAL THERAPY	9, 942	701, 386	0. 01417	5 127, 951	1, 814	67.00
68.00 06800 SPEECH PATHOLOGY	6, 639	237, 665	0. 02793	4 57, 844	1, 616	68.00
69.00 06900 ELECTROCARDI OLOGY	6,064	5, 868, 560	0. 00103	3 886, 677	916	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	61, 420	17, 400, 364	0.00353	0 2, 267, 064	8,003	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	154, 503	23, 235, 422	0. 00664	9 5, 749, 883	38, 231	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	79, 817			5 3, 290, 775		73.00
76. 00 03950 CARDI AC REHAB	22, 364	926, 630	0. 02413		0	76.00
OUTPATIENT SERVICE COST CENTERS			•			1
88.00 08800 RURAL HEALTH CLINIC	187, 725	3, 757, 687	0. 04995	8 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	413, 738	13, 456, 386	0. 03074	7 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	26, 764				0	88.02
91.00 09100 EMERGENCY	391, 884				17, 710	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	136, 672					92.00
200.00   Total (lines 50 through 199)	3, 303, 341			26, 013, 719		

Health Financial Systems	HENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	ER PASS THROUGH COS			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Healt	h Allied Health	All Other	
	School	School	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	C	31.00
43. 00 04300 NURSERY	0	0		0 0	C	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	t Per Diem	Inpati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)	5 5	
		minus col. 4)				
	4.00	5,00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	7,30	6 0.00	2, 568	30.00
31.00 03100 INTENSIVE CARE UNIT		0	1, 39	1 0.00	623	31.00
43.00 04300 NURSERY		0	55	9 0.00	0	43.00
200.00 Total (lines 30 through 199)		0	9, 25			200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 I NTENSI VE CARE UNI T	0					31.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	1					1

Health Financial Systems HE	ENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments		-		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS			_			
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 00 03950 CARDI AC REHAB	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	0	0		0 0	0	88.02
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00
				i.		•

Health Financial Systems HE	ENRY COUNTY MEM	IORIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2020 To 12/31/2020		narod
				10 12/31/2020	7/30/2021 9:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
	4.00	F 00	( 00	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	0		0 34, 563, 765	0. 000000	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0 2, 385, 931		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 18, 445, 314		1
57. 00 05700 CT SCAN	0			0 28, 910, 397		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 7, 867, 604		
59. 00 05900 CARDIAC CATHETERIZATION	0			0 7,807,004	0.000000	
60. 00 06000 LABORATORY	0			0 41, 909, 828		
60. 01 06001 BLOOD LABORATORY	0			0 41, 909, 020	0.000000	1
65. 00 06500 RESPIRATORY THERAPY	0			0 5, 397, 787		
66. 00 06600 PHYSI CAL THERAPY	0			0 3,677,474		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 701, 386		1
68. 00 06800 SPEECH PATHOLOGY	0	0		0 237, 665		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 5, 868, 560		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 17, 400, 364		1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 23, 235, 422		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 11, 729, 359	0. 000000	73.00
76. 00 03950 CARDI AC REHAB	0	0		0 926, 630	0. 000000	76.00
OUTPATIENT SERVICE COST CENTERS		•	•			1
88.00 08800 RURAL HEALTH CLINIC	0	0		0 3, 757, 687	0.000000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 13, 456, 386	0. 000000	88.01
88.02 08802 RURAL HEALTH CLINIC III	0	0		0 443, 199	0. 000000	88.02
91.00 09100 EMERGENCY	0	0		0 48, 272, 264	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1, 767, 164	0. 000000	92.00
200.00   Total (lines 50 through 199)	0	0		0 270, 954, 186		200.00

Health Financial Systems H	ENRY COUNTY MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	3	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	1 1			1		
50.00 05000 OPERATING ROOM	0. 000000	3, 262, 707		0 6, 464, 759		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 574		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1,007,009		0 4, 459, 974		54.00
57.00 05700 CT SCAN	0. 000000	1, 220, 394		0 6, 513, 068		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	166, 416		0 1, 829, 674	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	4, 243, 209		0 2, 688, 930	0	60.00
60.01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 084, 653		0 210, 394	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	380, 372		0 16, 583	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	127, 951		0 1, 608	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	57, 844		0 2, 050	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	886, 677		0 2, 146, 906	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	2, 267, 064		0 1, 799, 521	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	5, 749, 883		0 6, 187, 183	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	3, 290, 775		0 4, 564, 189	0	73.00
76. 00 03950 CARDI AC REHAB	0. 000000	0		0 191, 614	0	76.00
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000	0		0 0	0	88.02
91.00 09100 EMERGENCY	0. 000000	2, 181, 609		0 7, 711, 391	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	87, 156		0 522, 196	0	92.00
200.00 Total (lines 50 through 199)		26, 013, 719		0 45, 310, 614	0	200. 00

Health Financial Systems HE	ENRY COUNTY MEN	IORIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pre 7/30/2021 9:1	
		Title	Title XVIII		PPS	
			Charges	Hospi tal	Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
cost center bescription	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Servi ces (see		Servi ces Not	(366 1131.)	
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.	11131.7	Ded. & Coins.			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
50.00 05000 OPERATING ROOM	0. 254983	6, 464, 759		0 0	1, 648, 404	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 188377	574		0 0	108	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 244049	4, 459, 974		0 0	1,088,452	54.00
57.00 05700 CT SCAN	0. 027299	6, 513, 068		0 0	177, 800	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 056128	1, 829, 674		0 0	102, 696	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			0 0	0	1
60. 00 06000 LABORATORY	0. 187495		40	0 0	504, 161	60.00
60. 01 06001 BLOOD LABORATORY	0.000000			0 0	0	•
65. 00 06500 RESPIRATORY THERAPY	0. 342599			0 0	72, 081	•
66. 00 06600 PHYSI CAL THERAPY	1.009971			0 0	16, 748	•
67.00 06700 OCCUPATI ONAL THERAPY	0. 577770			0 0	929	
68.00 06800 SPEECH PATHOLOGY	0. 674580			0 0	1, 383	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 089516			0 0	192, 182	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 170158			0 0	306, 203	•
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 323902			0 0	2,004,041	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 429626			1, 318		
76. 00 03950 CARDI AC REHAB	0. 279163			0 0	53, 492	
OUTPATIENT SERVICE COST CENTERS				-1 -		1
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88.01
88.02 08802 RURAL HEALTH CLINIC III						88.02
91. 00 09100 EMERGENCY	0. 139285	7, 711, 391		o o	1, 074, 081	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 779853			0 0	407, 236	
200.00 Subtotal (see instructions)		45, 310, 614			9, 610, 891	
201.00 Less PBP Clinic Lab. Services-Program				0 0	., , . , . ,	201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		45, 310, 614	40	0 1, 318	9, 610, 891	202.00

	ENRY COUNTY MEN			In Lieu	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pr 7/30/2021 9:	
	1		XVIII	Hospi tal	PPS	_
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS			-			
50. 00 05000 OPERATI NG ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	75	l o				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60.01
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	566				73.00
76. 00 03950 CARDI AC REHAB	0	0				76.00
OUTPATIENT SERVICE COST CENTERS	0	0				- 70.00
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88.0
	-					88.02
	0	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.0
200.00 Subtotal (see instructions)	75					200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 - line 201)	75	566				202.00

# HENRY COUNTY MEMORIAL HOSPITAL

Heal th	Financial Systems HENRY COUNTY MEMORI	AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0030	Peri od:	Worksheet D-1	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
			10 12/01/2020	7/30/2021 9:1	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
1.00	Inpatient days (including private room days and swing-bed day	(s excluding newborn)		7, 306	1.00
2.00	Inpatient days (including private room days, excluding swing-			7, 306	2.00
3.00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	3.00
	do not complete this line.		-		
4.00	Semi-private room days (excluding swing-bed and observation b			6, 415	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decemb	er 31 of the cost	0	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private ro	om dave) after December	21 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	ioni days) al ter becenber	ST OF THE COST	0	0.00
7.00	Total swing-bed NF type inpatient days (including private roc	m days) through Decembe	r 31 of the cost	0	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private roc	om 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 t	the Program (excludin	g swing-bed and	2, 568	9.00
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII c	nly (including privato	room dave)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		i oom uays <i>j</i>	0	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e				
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	12.00
	through December 31 of the cost reporting period				
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.00
14.00	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	14.00
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT			-	
17.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	17.00
	reporting period				
18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 21 a	f the cost	0.00	19.00
19.00	reporting period	s through becember 51 0	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instruction			11, 300, 310	
22.00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22.00
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporti	ng poriod (line A	0	23.00
23.00	x line 18)	ST OF THE COST TEPOLT	ng period (inne d	0	23.00
24.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24.00
	7 x line 19)		5 m · · · · ·		
25.00		31 of the cost reportin	g period (line 8	0	25.00
0/ 5-	x line 20)			_	
26.00	Total swing-bed cost (see instructions)	(Line 21 minus Line 2()		11 200 210	
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)		11, 300, 310	27.00
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed o	harges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			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 mi		CTI ONS)	0.00	
35.00 36.00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0. 00 0	35.00 36.00
36.00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line		
57.00	27 minus line 36)	and private room cost u			37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			1
38.00	Adjusted general inpatient routine service cost per diem (see			1, 546. 72	
39.00	Program general inpatient routine service cost (line 9 x line	-		3, 971, 977	39.00
40.00	Medically necessary private room cost applicable to the Progr			0 3, 971, 977	
41.00	Total Program general inpatient routine service cost (line 39				

OMPUT	Financial Systems TATION OF INPATIENT OPERATING COST		Provider C		Peri od:	u of Form CMS- Worksheet D-1	
					From 01/01/2020		
					To 12/31/2020	Date/Time Pre 7/30/2021 9:	epare 15 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient	Inpati ent	Diem (col. 1		(col. 3 x	
		<u>Cost</u> 1.00	<u>Days</u> 2.00	÷ col. 2) 3.00	4.00	<u>col. 4)</u> 5.00	
. 00	NURSERY (title V & XIX only)	0	0				42.
	Intensive Care Type Inpatient Hospital Un	ni ts		1			
. 00	I NTENSI VE CARE UNI T	3, 961, 032	1, 391	2,847.6	623	1, 774, 061	
. 00	CORONARY CARE UNIT						44
. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45
	OTHER SPECIAL CARE (SPECIFY)						40
	Cost Center Description						
						1.00	
. 00	Program inpatient ancillary service cost			>		6, 899, 306	
. 00	Total Program inpatient costs (sum of lir PASS THROUGH COST ADJUSTMENTS	nes 41 through 48)(	see Instructi	ons)		12, 645, 344	49
. 00	Pass through costs applicable to Program	inpatient routine	services (fro	m Wkst. D. su	m of Parts I and	573, 342	2 50
	)						
. 00	Pass through costs applicable to Program	inpatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	259, 148	3 51
	and IV)	200 EQ and E1)				000 400	
2.00	Total Program excludable cost (sum of lir Total Program inpatient operating cost ex		lated non ph	veician anost	botist and	832, 490 11, 812, 854	
. 00	medical education costs (line 49 minus li		nateu, non-pri	ysi ci all'allest		11, 012, 034	F 33
	TARGET AMOUNT AND LIMIT COMPUTATION	110 02)					
. 00	Program di scharges					C	54
. 00						0.00	
. 00	Target amount (line 54 x line 55)					C	
. 00	Difference between adjusted inpatient ope	erating cost and ta	irget amount (	line 56 minus	line 53)	0	
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost	t reporting pariod	onding 1004	undated and a	ompounded by the	0.00	
. 00	market basket	reporting period	enurng 1990,		unpounded by the	. 0.00	57
. 00	Lesser of lines 53/54 or 55 from prior ye	ear cost report, up	dated by the	market basket		0.00	60
. 00	If line 53/54 is less than the lower of I					C	) 61
	which operating costs (line 53) are less		s (lines 54 x	60), or 1% o	f the target		
	amount (line 56), otherwise enter zero (s	see instructions)					
. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive p	avmont (soo instru	uctions)			0	) 62 ) 63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST	Jayment (see mistre				L C	1 03
. 00	Medicare swing-bed SNF inpatient routine	costs through Dece	mber 31 of th	e cost report	ing period (See	C	64
	instructions)(title XVIII only)						
5.00	Medicare swing-bed SNF inpatient routine	costs after Decemb	er 31 of the	cost reportin	g period (See	C	65
5.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient ro	outino coste (lino	64 plus lipo	45) (+i +l o VVI	LL only) For	C	66
5.00	CAH (see instructions)		04 prus rine	05)((1118 XV)	ri oniy). Toi	C C	
. 00	Title V or XIX swing-bed NF inpatient rou	utine costs through	December 31	of the cost r	eporting period	C	67
	(line 12 x line 19)	-					
3. 00	Title V or XIX swing-bed NF inpatient rou	utine costs after D	ecember 31 of	the cost rep	orting period	C	68
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatie	ent routine costs (	line 67 + lin	e 68)		C	69
. 00	PART III - SKILLED NURSING FACILITY, OTHE						4 07
0. 00	Skilled nursing facility/other nursing fa				)		70
. 00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x li	,	/11.				72
. 00	Medically necessary private room cost app	0		,			73
. 00	Total Program general inpatient routine s Capital-related cost allocated to inpatie				Part II column		74
. 50	26, line 45)						' '
. 00	Per diem capital-related costs (line 75 +	+ line 2)					76
. 00	Program capital-related costs (line 9 x l						77
00	Inpatient routine service cost (line 74 m	,		de)			78
00	Aggregate charges to beneficiaries for ex	• •			nuc line 70)		79
00 00	Total Program routine service costs for c Inpatient routine service cost per diem I	•	ost i i mitati O		INS IT UN (9)		80
. 00	Inpatient routine service cost per drem i		)				82
. 00	Reasonable inpatient routine service cost	•					83
. 00	Program inpatient ancillary services (see		-				84
. 00	Utilization review - physician compensati	on (see instruction					85
. 00	Total Program inpatient operating costs (		rough 85)				86
	PART IV - COMPUTATION OF OBSERVATION BED					004	
7.00	Total observation bed days (see instructi		1: 2)			891 1, 546. 72	
3.00	Adjusted general inpatient routine cost p						

Health Financial Systems HE	ENRY COUNTY MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-		
COMPUTATION OF INPATIENT OPERATING COST		Provider CC	Provider CCN: 15-0030		Worksheet D-1	
				From 01/01/2020 To 12/31/2020		nared
				10 12/31/2020	7/30/2021 9:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 120, 674	11, 300, 310	0. 09917	2 1, 378, 128	136, 672	90.00
91.00 Nursing School cost	0	11, 300, 310	0.00000	0 1, 378, 128	0	91.00
92.00 Allied health cost	0	11, 300, 310	0.00000	0 1, 378, 128	0	92.00
93.00 All other Medical Education	0	11, 300, 310	0.00000	0 1, 378, 128	0	93.00

## HENRY COUNTY MEMORIAL HOSPITAL

<u>Heal t</u> h	Financial Systems HENRY COUNTY MEMOR		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0030	Peri od:	Worksheet D-1	
			From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
		Title XIX	Hospi tal	Cost	
	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 day			7,306	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed days)		vrivato room dave	7, 306 0	2.00 3.00
3.00	do not complete this line.	ays). It you have only p	in vate room days,		3.00
4.00	Semi-private room days (excluding swing-bed and observation I	bed days)		6, 415	4.00
5.00	Total swing-bed SNF type inpatient days (including private re	oom days) through Decemb	er 31 of the cost	0	5.00
( 00	reporting period		01 - <del>C</del> + h +		( 00
6.00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private row	om days) through Decembe	er 31 of the cost	0	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8.00
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (oveludin	a swing bod and	229	9.00
9.00	newborn days) (see instructions)		ig swillig-bed allo	227	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private	room days)	0	10.00
	through December 31 of the cost reporting period (see instru				
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, of		room days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or X		ite room days)	0	12.00
12100	through December 31 of the cost reporting period		dajo)		12100
13.00	Swing-bed NF type inpatient days applicable to titles V or X			0	13.00
11.00	after December 31 of the cost reporting period (if calendar				11.00
14.00 15.00	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	ram (excluding swing-bed	(days)	0 559	
16.00	Nursery days (title V or XIX only)			0	1
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	17.00
10.00	reporting period	ft D 21 -f		0.00	10.00
18.00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	the cost	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	of the cost	0.00	19.00
	reporting period	C C			
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.00
21.00	reporting period Total general inpatient routine service cost (see instruction	ns)		11, 300, 310	21.00
22.00	Swing-bed cost applicable to SNF type services through Decem		ting period (line		22.00
	5 x line 17)	·	51 (		
23.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24.00
24.00	7 x line 19)	er 51 01 the cost report	ing period (inne		24.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	ng period (line 8	0	25.00
	x line 20)				
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 11, 300, 310	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 20)		11, 300, 310	27.00
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00 32.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ TTHE 28)		0.000000	
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 mi	inus line 33)(see instru	icti ons)	0.00	
35.00	Average per diem private room cost differential (line 34 x li	ine 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room cast -	lifforontial (li	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost d		11, 300, 310	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
38.00	Adjusted general inpatient routine service cost per diem (see			1, 546. 72	
39.00 40.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Prog	-		354, 199 0	1
40.00 41.00		•		354, 199	40.00
	1.2.2			007,177	

	Financial Systems H	ENRY COUNTY MEMO	Provider C		Peri od:	u of Form CMS- Worksheet D-	
					From 01/01/2020 To 12/31/2020		
						7/30/2021 9:	
	Cost Center Description	Total		e XIX Average Per	Hospital Program Days	Cost Program Cost	
	cost center bescription	Inpatient	Inpatient	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col. 2)		col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	1, 227, 246	559	2, 195. 4	3 0	(	) 42
	Intensive Care Type Inpatient Hospital Units				-		
. 00	I NTENSI VE CARE UNI T	3, 961, 032	1, 391	2,847.6	1 0	(	) 43
. 00	CORONARY CARE UNIT						44
. 00 . 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45
	OTHER SPECIAL CARE (SPECIFY)						40
. 00	Cost Center Description						11
						1.00	
. 00	Program inpatient ancillary service cost (W					250, 793	
. 00	Total Program inpatient costs (sum of lines	41 through 48)(	see instructio	ons)		604, 992	2 49
00	PASS THROUGH COST ADJUSTMENTS	ationt routing	annul and (from	what D and	n of Dorto I one		
. 00	Pass through costs applicable to Program inp	batrent routine	services (IIO	II WKSL. D, SUI	I OF Parts F and	l l	50
. 00	Pass through costs applicable to Program ing	natient ancillar	v services (fi	com Wkst D	sum of Parts II	(	51
	and IV)		, <b>(</b>				
. 00	Total Program excludable cost (sum of lines					(	52
8.00	Total Program inpatient operating cost exclu		lated, non-phy	ysician anestl	netist, and	(	53
	medical education costs (line 49 minus line	52)					_
00	TARGET AMOUNT AND LIMIT COMPUTATION						54
. 00	Program discharges Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)						56
. 00	Difference between adjusted inpatient operat	ting cost and ta	rget amount (l	ine 56 minus	line 53)		5 57
. 00	Bonus payment (see instructions)						58
. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996, u	updated and co	ompounded by the	0.00	
	market basket		-				
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line					(	) 61
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	r the target		
2. 00	Relief payment (see instructions)	riisti ucti olisj				ſ	62
. 00	Allowable Inpatient cost plus incentive payr	ment (see instru	icti ons)				63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 31 of the	e cost reporti	ng period (See	(	64
	instructions)(title XVIII only)						
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	er 31 of the o	cost reporting	g period (See	(	) 65
. 00	Total Medicare swing-bed SNF inpatient routi	ine costs (line	64 nlus line /	45)(+i+lXV/I	Lonly) For	C	66
. 00	CAH (see instructions)		04 prus rifle (	55)(title xvi	i oniy). Toi	(	
7.00	Title V or XIX swing-bed NF inpatient routir	ne costs through	December 31 d	of the cost re	eporting period	(	67
	(line 12 x line 19)	5			5 1 5 1		
3.00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost rep	orting period	(	) 68
	(line 13 x line 20)						
9.00	Total title V or XIX swing-bed NF inpatient					(	D 69
0. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				\		70
. 00	Adjusted general inpatient routine service of				)		71
. 00	Program routine service cost (line 9 x line			-/			72
. 00	Medically necessary private room cost applic		n (line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv	0					74
5.00	Capital-related cost allocated to inpatient	routine service	e costs (from \	Norksheet B, I	Part II, column		75
00	26, line 45)	no 2)					-,
. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
. 00	Inpatient routine service cost (line 74 minu						78
. 00	Aggregate charges to beneficiaries for excess		rovi der record	ds)			79
00	Total Program routine service costs for comp				nus line 79)		80
. 00	Inpatient routine service cost per diem limi				-		81
. 00	Inpatient routine service cost limitation (I		· .				82
. 00	Reasonable inpatient routine service costs (	•	is)				83
. 00	Program inpatient ancillary services (see in						84
. 00	Utilization review - physician compensation	•					85
. 00	Total Program inpatient operating costs (sur PART IV - COMPUTATION OF OBSERVATION BED PAS		n ough 65)				
. 00	Total observation bed days (see instructions					89	1 87
	<b>3</b> • •		lino 2)				
8.00	Adjusted general inpatient routine cost per					1, 546. 72	2 00

Health Financial Systems HE	ENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Period:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre	
		Ti †I	e XIX	Hospi tal	7/30/2021 9: 1 Cost	5 am
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH						
90.00 Capital-related cost	1, 120, 674			2 1, 378, 128	136, 672	90.00
91.00 Nursing School cost	0	11, 300, 310	0. 00000	0 1, 378, 128	0	91.00
92.00 Allied health cost	0	11, 300, 310	0.00000	0 1, 378, 128	0	92.00
93.00 All other Medical Education	0	11, 300, 310	0.00000	0 1, 378, 128	0	93.00

31.00       03100       INTENSI VE CARE UNIT       1,937,831       31.0         43.00       04300       NURSERY       43.0         50.00       05000       OPERATI NG ROOM       0.254983       3,262,707       831,935       50.0         52.00       05200       DELI VERY ROOM & LABOR ROOM       0.244049       1,007,009       245,760       54.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.244049       1,007,009       245,760       54.00         55.00       05500       CT SCAN       0.027299       1,220,394       33.316       57.00         57.00       05500       CARDI AC CATHETERI ZATI ON       0.000000       0       59.00         58.00       05600       ARDIA CATHETERI ZATI ON       0.000000       0       59.00         60.01       BLOOD LABORATORY       0.342599       1,084,653       371,601       65.00         60.00       06600       PHYSI CAL THERAPY       0.342599       1,084,653       371,601       65.00         64.00       06600       PHYSI CAL THERAPY       0.577770       127,951       73,926       67.00         65.00       06600 SPEECH PATHOLOGY       0.674580       57,844       39.020       68.0	Health Financial Sy	stems	HENRY COUNTY MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
Cost Center Description         Title XVIII         Hospital         PPS           Ratio of Cost Cont Center Description         Ratio of Cost To Charges         Inpatient Program Charges         Inpatient Program Charges         Inpatient Program Charges         Inpatient Program Costs (col. 1 x col. 2)         Inpatient Program Costs (col. 1 x col. 2)           30.00         03000         ADUITS & PEDIATRICS         4,096,936         30.00           31.00         03100         INTENSIVE CARE UNIT         1,937,831         30.0           43.00         04300         NURSERY         0.254983         3,262,707         831,935         50.0           50.00         05400         RADIOLOGY - DI AGNOSTI C         0.254983         3,262,707         831,935         50.0           50.00         05400         RADIOLOGY - DI AGNOSTI C         0.254983         3,262,707         831,935         50.0           50.00         05500         RADIOLOGY - DI AGNOSTI C         0.254983         3,262,707         831,935         50.0           50.00         05500         CARDIAC CATHETERI ZATION         0.027299         1,220,394         33,316         57.00           50.00         05500         MARDIA CATHETERI ZATION         0.05000         0.06000         0.06000         0.06000         0.06000	INPATIENT ANCILLARY	SERVICE COST APPORTIONMENT	Pro	ovider C		From 01/01/2020	Date/Time Pre	pared:
Cost Center Description         Ratio of Cost To Charges         Inpatient Program Costs (col. 1 x col. 2)         Inpatient Program Costs (col. 1 x col. 2)           1.00         2.00         3.00           30.00         03000 ADULTS & PEDIATRICS         4,096,936         30.0           31.00         03100 INTENSIVE CABE UNIT         4,096,936         31.0         43.0           43.00         05200 DELIVERY ROOM         0.254983         3,262,707         831,935           50.00         05200 DELIVERY ROOM         0.188377         0         52.0           51.00         05200 DELIVERY ROM & LABOR ROOM         0.244049         1,007,009         245,760         54.0           50.00         05200 ODELIVERY ROM & LABOR ROOM         0.025128         166,416         9,341         58.0           50.00         05200 ODELIVERY ROM & LABOR ROOM         0.025408         1,007,009         245,760         54.0           50.00         05200 ODELIVERY ROM         0.025418         166,416         9,341         58.0           50.00         05600 CARDIA C. CATHETERIZION         0.000000         0         0         66.0           60.00         06000 RESPI RATION         0.030200 RESPI RATION         0.030200 RESPI RATION         0.030200 RESPI RATION         0.000000 O				Ti tl o	XV/LLL	Hocni tol		<u>5 am</u>
INPATI ENT ROUTI NE SERVI CE COST CENTERS         Program (Costs) (col. 1 x, col. 2)           30. 00         03000 ADULTS & PEDI ATRI CS         1.00         2.00         3.00           41.000         04300         NULTS & PEDI ATRI CS         4.096,936         30.0           41.00         04300         NULTS & PEDI ATRI CS         1.937,831         41.00           43.00         04300         NURSERY         1.937,831         41.09           ANCILLARY SERVICE COST CENTERS         0.254983         3.262,707         831,935           0.00         05000         DEVID (VOL VOL ADROSTIC         0.244049         1.007.009         245,760         54.0           052.00         05500         CARON CHARONTIC         0.244049         1.007.009         245,760         54.0           054.00         05500         CARONTIC RESONANCE IMAGI NG (MRI )         0.056128         166,416         9,341         58.0           059.00         05500 CARDI AC CATHETERI ZATI ON         0.000000         0         0         0.57           06.00         06500 RESPI RATORY         0.342599         1.846,543         371,601         65.0           06.00         06500 RESPI RATORY         0.577770         127,951         73,926         67.0 <t< td=""><td>Cost Co</td><td>nton Decerintian</td><td></td><td>ntie</td><td></td><td></td><td></td><td></td></t<>	Cost Co	nton Decerintian		ntie				
INPATI ENT ROUTI NE SERVICE COST CENTERS         Col. 2)           1.00         2.00         3.00           0.00         03000 ADULTS & PEDI ATRICS         4.096,936         30.0           1.00         04300 NURSERY         1.937,831         31.0           43.00         043000 NURSERY         0.254983         3.262,707         831,935         50.0           50.00         05000 DEPERATI NG ROOM         0.188377         0         0.52.0         052.00         052.00         052.00         052.00         052.00         052.00         052.00         052.00         0.254983         3.262,707         831,935         50.0         0.52.00<	COST CE	enter Description						
INPATI ENT ROUTI NE SERVI CE COST CENTERS         1.00         2.00         3.00           30.00         03000 (ADULTS & PEDI ATRI CS         4,096,936         30.0           31.00         03100 (INTENSI VE CARE UNI T         1,937,831         31.0           43.00         04300 (NURSERY         43.0           ANCI LLARY SERVI CE COST CENTERS         50.00         05000 (OPERATING ROOM         0.254983         3,262,707         831,935         50.00         52.00         05200 DEL VERY ROUM & LABOR ROOM         0.2240491         0,07.009         245,760         54.00         55.00         055000 (OPERATING ROOM         0.52.00         05200 DEL VERY ROUM & LABOR ROOM         0.2240491         1,207,394         33.316         57.00         55.00         05600 MAGNETI C RESONANCE I MAGI NG (MRI )         0.056128         166.416         9,341         59.00         05900 (CARDI AC CATHETERI ZATI ON         0.000000         0         0         60.00         60.00         60.00         0.000000         0         60.00					TO Charges			
INPATI ENT ROUTINE SERVICE COST CENTERS           30.00         03000 ADULTS & PEDIATRICS         4,096,936         31.00           31.00         03100 INTENSIVE CARE UNIT         1,937,831         31.0           43.00         04300 NURSERY         1,937,831         43.0           ANCI LLARY SERVICE COST CENTERS         05200 DELIVERY ROOM & LABOR ROOM         0.188377         0         052.00           52.00         05200 DELIVERY ROOM & LABOR ROOM         0.254983         3,262,707         831,935         50.00           54.00         05400 RADI OLGGY-DI AGNOSTI C         0.244049         1,007,009         245,760         54.00           55.00         05500 DELIVERY ROOM & LABOR ROOM         0.254983         3,262,707         831,31,615.00         58.00           50.00         05500 CARDI AC CATHETERI ZATI ON         0.022991         1,220,394         33,316         57.00           50.00         05800 IMAGNETI C RESONANCE IMAGI NG (MRI )         0.056128         166.416         9,341         58.0           50.00         05800 CARDI AC CATHETERI ZATI ON         0.000000         0         0         69.00           60.00         06000 LABORATORY         0.342599         1,084,653         371,601         65.00           60.00         06600 PHEYSI CAL T						charges		
INPATI ENT ROUTI NE SERVICE COST CENTERS         30. 00         030000         03000 ADULTS & PEDI ATRI CS         30. 00					1 00	2 00		
30.00       03000       ADULTS & PEDI ATRICS       4,096,936       30.0         31.00       03000       INTENSIVE CARE UNIT       1,937,831       31.0         43.00       04300       NURSERV       43.0         ANCILLARY SERVICE COST CENTERS	INPATIENT ROL	JTINE SERVICE COST CENTERS			1.00	2.00	0.00	
31.00       03100       INTENSIVE CARE UNIT       1, 937, 831       31.0         43.00       04300       NURSERY       43.0       0.254983       3, 262, 707       831, 935       50.0       43.0         50.00       05000       OPERATING ROOM       0.188377       0       0       52.00       05200       DELIVERY ROOM & LABOR ROOM       0.244049       1, 007, 009       245, 760       54.00       54.00       0.5500       RABIOLOGY-DI AGNOSTIC       0.244049       1, 007, 009       245, 760       54.00       55.00       0.05700       CT SCAN       0.027299       1, 220, 394       33, 316       57.00       55.00       05500       AGRIA CATHETERIZATION       0.000000       0       59.00       0.05000       LABORATORY       0.000000       0       0       59.00       0.000000       0       0       60.00       0.00000       0       0       60.00       0.00000       0       0       60.00       0.00000       0       0       60.00       0.00000       0       0       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>4, 096, 936</td> <td></td> <td>30.00</td>						4, 096, 936		30.00
43.00       04300       NURSERY       43.0         ANCILLARY SERVICE COST CENTERS       43.0         52.00       05000       DERATING ROOM       0.254983       3.262,707       831,935       50.00       52.00         52.00       05200       DELIVERY ROOM & LABOR ROOM       0.188377       0       52.00       52.00         54.00       05400       RADIOLOGY-DIAGNOSTIC       0.244049       1,007,009       245,760       54.00         58.00       05800       RAGNETIC RESONANCE IMAGING (MRI)       0.056128       166,416       9,341       58.00         05900       CARDIAC CATHETERIZATION       0.000000       0       0       59.00       05900       CARDARTORY       0.187495       4,23,209       795,580       60.00								31.00
50.00       05000       OPERATING ROOM       0.254983       3, 262, 707       831, 935       50.0         52.00       05200       DELI VERY ROOM & LABOR ROOM       0.188377       0       0       52.0         54.00       05400       RADI LOGY-DI AGNOSTI C       0.244049       1,007,009       245,765       40.0         57.00       05700       CT SCAN       0.027299       1,220,394       33,316       57.0         59.00       05800       MACNETI C RESONANCE I MAGI NG (MRI )       0.056128       166,416       9,341       58.0         59.00       05900       CARDI AC CATHETERI ZATI ON       0.000000       0       059.0       0.000000       0       0.000000       0       0						, , , , , , , , , , , , , , , , , , , ,		43.00
52.00       05200       DELIVERY ROOM & LABOR ROOM       0.188377       0       0       52.00         54.00       05400       RADI 0L0GY-DI AGNOSTI C       0.244049       1,007,009       245,760       54.00         57.00       05700       CT SCAN       0.027299       1,220,394       33,316       57.00         58.00       05800       MAGNETI C RESONANCE IMAGING (MRI)       0.056128       166,416       9,341       58.00         59.00       05900       CARDI AC CATHETERI ZATI 0N       0.000000       0       0       59.00         60.01       D6000       LABORATORY       0.187495       4,243,209       795,580       60.00         60.01       06001       BLOOD LABORATORY       0.342599       1,084,653       371,601       65.00         65.00       06600       PHYSI CAL THERAPY       0.342599       1,084,653       371,601       65.00         66.00       06600       PHYSI CAL THERAPY       0.577770       127,951       73,926       67.00         67.00       06700       0CCUPATI ONAL THERAPY       0.674580       57.444       39,020       68.0         68.00       06800       SPEECH PATHOLOGY       0.823902       5.749,883       1,862,399       72.0	ANCI LLARY SEE	RVICE COST CENTERS						1
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.244049       1,007,009       245,760       54.0         57.00       05700       CT SCAN       0.027299       1,220,394       33,316       57.0         58.00       MAGNETI C RESONANCE I MAGI NG (MRI )       0.056128       166,416       9,341       58.00         59.00       OS900       CARDI AC CATHETERIZATI ON       0.000000       0       059.00         60.01       06001       BLORD LABORATORY       0.187495       4,243,209       795,580       60.0         65.00       O6500       RESPI RATORY THERAPY       0.342599       1,084,653       371,601       65.0         66.00       06600       PHYSI CAL THERAPY       0.577770       127,951       73,926       67.0         67.00       OC700       CCUPATI ONAL THERAPY       0.577770       127,951       73,926       67.0         68.00       O6800       SPECH PATHOLOGY       0.674580       57.84       39.020       68.0         69.00       O6900       ELECTROCARDI OLOGY       0.674580       57.49,883       1,862,399       72.0         72.00       O7200       IMPL. DEV. CHARGED TO PATI ENTS       0.1299163       0       72.0       72.00       72.00 <t< td=""><td>50.00 05000 0PERATI</td><td>NG ROOM</td><td></td><td></td><td>0. 25498</td><td>3 3, 262, 707</td><td>831, 935</td><td>50.00</td></t<>	50.00 05000 0PERATI	NG ROOM			0. 25498	3 3, 262, 707	831, 935	50.00
57.00       05700       CT SCAN       0.027299       1,220,394       33,316       57.0         58.00       05800       MAGNETIC RESONANCE IMAGING (MRI)       0.056128       166,416       9,341       58.0         59.00       05900       CARDIAC CATHETERIZATION       0.000000       0       0       970         60.00       06000       LABORATORY       0.187495       4,243,209       795,580       60.0         60.01       06001       BLOOD LABORATORY       0.342599       1,084,653       371,601       65.0         66.00       06600       PHYSICAL THERAPY       0.342599       1,084,653       371,601       65.0         67.00       06700       0CUPATIONAL THERAPY       0.577770       127,951       73,926       67.0         68.00       06800       SPEECH PATHOLOGY       0.57770       127,951       73,926       67.0         69.00       0CUPATIONAL THERAPY       0.577770       127,951       73,926       71.0         71.00       O7100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.17158       2,267,064       38,579       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.279163       0       73.0       73.0       0.3950	52.00 05200 DELI VER	RY ROOM & LABOR ROOM			0. 18837	7 0	0	52.00
58.00         05800         MAGNETIC RESONANCE IMAGING (MRI)         0.056128         166,416         9,341         58.0           59.00         05900         CARDIAC CATHETERIZATION         0.000000         0         0         59.0           60.00         06000         LABORATORY         0.187495         4,243,209         795,580         60.0           60.01         06001         BLODD LABORATORY         0.342599         1,084,653         371,601         65.0           65.00         06500         RESPI RATORY THERAPY         0.342599         1,084,653         371,601         65.0           66.00         06000         OVO0         0.577770         127,951         73,926         67.0           67.00         06700         OCUPATI ONAL THERAPY         0.577770         127,951         73,926         67.0           68.00         06800         SPECH PATHOLOGY         0.674580         57,844         39,020         68.0           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         0.170158         2,267,064         385,759         71.0           72.00         07200         IMPL. DEV. CHARGED TO PATIENT         0.323902         5,749,883         1,862,399         72.0           76.00	54.00 05400 RADI OLO	DGY-DI AGNOSTI C			0. 24404	9 1, 007, 009	245, 760	54.00
59.00       05900       CARDIAC CATHETERIZATION       0.000000       0       0       59.0         60.00       06000       LABORATORY       0.187495       4,243,209       795,580       60.0         60.01       06001       BLOOD LABORATORY       0.000000       0       0       06.00         65.00       06500       RESPI RATORY THERAPY       0.342599       1,084,653       371,601       65.00         66.00       06600       PHYSI CAL THERAPY       0.577770       127,951       73,926       67.00         67.00       06700       OCCUPATI ONAL THERAPY       0.577770       127,951       73,926       67.00         68.00       06800 SPEECH PATHOLOGY       0.674580       57,844       39,020       68.0         69.00       06900 ELECTROCARDI OLOGY       0.089516       88.6,677       79,372       69.0         71.00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.170158       2.267,064       385,759       71.0         72.00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0.279163       0       0       72.0         73.00       07300 DRUGS CHARGED TO PATI ENTS       0.279163       0       0       70.0         76.00       08800 RURAL HEALTH CLINIC II	57.00 05700 CT SCAN	J			0. 02729	9 1, 220, 394	33, 316	57.00
60.00       06000       LABORATORY       0.187495       4, 243, 209       795, 580       60.0         60.01       06001       BLOOD LABORATORY       0.000000       0       0       60.0         65.00       06500       RESPI RATORY THERAPY       0.342599       1, 084, 653       371, 601       65.0         66.00       06600       PHYSI CAL THERAPY       0.577770       127, 951       73, 926       67.00         67.00       06700       0CCUPATI ONAL THERAPY       0.577770       127, 951       73, 926       67.00         68.00       06800       SPEECH PATHOLOGY       0.674580       57, 844       39, 020       68.0         69.00       06900       ELECTROCARDI OLOGY       0.089516       886, 677       79, 372       69.0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.170158       2, 267, 064       385, 759       71.0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.429626       3, 290, 775       1, 413, 803       73.0         76.00       03950       CARDI AC REHAB       0.2179163       0       0       70.0         0       03800       RURAL HEALTH CLINI C II       0.000000       0       88.0       88.0<	58.00 05800 MAGNETI	C RESONANCE IMAGING (MRI)			0. 05612	8 166, 416	9, 341	58.00
60.01       06001       BLOOD LABORATORY       0.000000       0	59.00 05900 CARDI AC	CATHETERI ZATI ON			0.00000	0 0	0	59.00
65.00       06500       RESPI RATORY THERAPY       0.342599       1,084,653       371,601       65.0         66.00       06600       PHYSI CAL THERAPY       1.009971       380,372       384,165       66.0         67.00       06700       0CUPATI ONAL THERAPY       0.577770       127,951       73,926       67.0         68.00       06800       SPEECH PATHOLOGY       0.674580       57.844       39,020       68.0         69.00       06900       ELECTROCARDI OLOGY       0.089516       886,677       79,372       69.0         71.00       O7100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.170158       2,267,064       385,759       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       0.32392       5,749,883       1,862,399       72.0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.429626       3,290,775       1,413,803       73.0         76.00       03950       CARDI AC REHAB       0.279163       0       0       76.0         04800       RURAL HEALTH CLINIC II       0.000000       0       88.0       88.0         88.00       08800       RURAL HEALTH CLINIC III       0.000000       0       88.0         <	60.00 06000 LABORAT	TORY			0. 18749	4, 243, 209	795, 580	60.00
66.00         06600         PHYSI CAL THERAPY         1.009971         380, 372         384, 165         66.0           67.00         06700         OCUPATI ONAL THERAPY         0.577770         127, 951         73, 926         67.0           68.00         06800         SPEECH PATHOLOGY         0.674580         57, 844         39, 020         68.0           69.00         06900         ELECTROCARDI OLOGY         0.674580         57, 844         39, 020         68.0           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0.170158         2, 267, 064         385, 759         71.0           72.00         07200         IMPL DEV. CHARGED TO PATI ENT         0.323902         57, 749, 883         1, 862, 399         72.0           73.00         07300         DRUGS CHARGED TO PATI ENTS         0.429626         3, 290, 775         1, 413, 803         73.0           76.00         03950         CARDI AC REHAB         0.279163         0         0         76.0           0         08800         RURAL HEALTH CLINIC         0.000000         0         88.0           88.00         08800         RURAL HEALTH CLINIC C II         0.000000         0         88.0           88.01         08801	60.01 06001 BLOOD L	ABORATORY			0.00000	0 0	0	60.01
67.00       06700       OCCUPATI ONAL THERAPY       0.577770       127,951       73,926       67.0         68.00       06800       SPEECH PATHOLOGY       0.674580       57,844       39,020       68.0         69.00       06900       ELECTROCARDI OLOGY       0.089516       886,677       79,372       69.0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.170158       2,267,064       385,759       71.0         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.323902       5,749,883       1,862,399       72.0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.429626       3,290,775       1,413,803       73.0         76.00       03950       CARDI AC REHAB       0.279163       0       0       76.0         017017       08800       RURAL HEALTH CLINIC       0.000000       0       88.0       88.0         88.00       08800       RURAL HEALTH CLINIC 111       0.000000       0       88.0       88.0         88.02       08802       RURAL HEALTH CLINIC 111       0.000000       0       88.0       88.0         88.02       08802       RURAL HEALTH CLINIC 111       0.139970       2, 181,609       3	65.00 06500 RESPI RA	ATORY THERAPY					371, 601	65.00
68.00       06800       SPEECH PATHOLOGY       0.674580       57,844       39,020       68.0         69.00       06900       ELECTROCARDI OLOGY       0.089516       886,677       79,372       69.0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.170158       2,267,064       385,759       71.0         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENT       0.323902       5,749,883       1,862,399       72.0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.429626       3,290,775       1,413,803       73.0         76.00       03950       CARDI AC REHAB       0.279163       0       0       0         04000       08800       RURAL HEALTH CLINIC       0.000000       0       88.0         88.00       08802       RURAL HEALTH CLINIC 11       0.000000       0       88.0         88.02       08802       RURAL HEALTH CLINIC 111       0.000000       0       88.0         91.00       09100       EMERGENCY       0.139970       2,181,609       305,360       91.0         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       0.779853       87,156       67,969       92.0	66.00 06600 PHYSI CA	AL THERAPY			1.00997	1 380, 372	384, 165	66.00
69.00       06900       ELECTROCARDI OLOGY       0.089516       886, 677       79, 372       69.0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.170158       2, 267, 064       385, 759       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0.323902       5, 749, 883       1, 862, 399       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       0.429626       3, 290, 775       1, 413, 803       73.0         76.00       03950       CARDIA C REHAB       0.279163       0       0       76.0         0UTPATIENT SERVICE COST CENTERS       0.8800       RURAL HEALTH CLINIC       88.0       88.0       88.0         88.00       08800       RURAL HEALTH CLINIC       0.000000       0       88.0         88.01       08801 RURAL HEALTH CLINIC II       0.000000       0       88.0         88.02       08802 RURAL HEALTH CLINIC III       0.000000       0       88.0         91.00       09100       EMERGENCY       0.139970       2, 181, 609       305, 360       91.0         92.00       09200       OBSERVATION BEDS (NON-DI STINCT PART)       0.779853       87, 156       67, 969       92.0	67.00 06700 0CCUPAT	I ONAL THERAPY			0. 57777	0 127, 951	73, 926	67.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.170158       2,267,064       385,759       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0.323902       5,749,883       1,862,399       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       0.429626       3,290,775       1,413,803       73.0         76.00       03950       CARDI AC REHAB       0.279163       0       0       70.0         0       08800       RURAL HEALTH CLINIC       0.000000       0       88.0       88.00         88.00       08800       RURAL HEALTH CLINIC II       0.000000       0       88.0       88.0         88.01       08801       RURAL HEALTH CLINIC III       0.000000       0       88.0         88.02       08802       RURAL HEALTH CLINIC III       0.000000       0       88.0         91.00       09100       EMERGENCY       0.139970       2,181,609       305,360       91.0         92.00       09200       OBSERVATION BEDS (NON-DI STINCT PART)       0.779853       87,156       67,969       92.0	68.00 06800 SPEECH	PATHOLOGY			0. 67458	57, 844	39, 020	68.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0.323902       5,749,883       1,862,399       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       0.429626       3,290,775       1,413,803       73.0         76.00       03950       CARDIAC REHAB       0.279163       0       0       76.0         0UTPATIENT SERVICE COST CENTERS       0.8800       RURAL HEALTH CLINIC       0.000000       88.0         88.00       08800       RURAL HEALTH CLINIC II       0.000000       0       88.0         88.01       08801       RURAL HEALTH CLINIC III       0.000000       0       88.0         88.02       08802       RURAL HEALTH CLINIC III       0.000000       0       88.0         91.00       09100       EMERGENCY       0.139970       2,181,609       305,360       91.0         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0.779853       87,156       67,969       92.0	69.00 06900 ELECTRO	CARDI OLOGY			0. 08951			69.00
73.00         07300         DRUGS CHARGED TO PATIENTS         0.429626         3,290,775         1,413,803         73.0           76.00         03950         CARDIAC REHAB         0.279163         0         0         76.0           0UTPATIENT SERVICE COST CENTERS         0.000000         0         88.0         88.0         0.8800         RURAL HEALTH CLINIC         0.000000         0         88.0         88.0         98801         RURAL HEALTH CLINIC II         0.000000         0         88.0         88.0         9802         RURAL HEALTH CLINIC II         0.000000         0         88.0         88.0         91.00         0.9100         EMERGENCY         0.139970         2, 181,609         305,360         91.00         92.00         09200         0BSERVATION BEDS (NON-DI STINCT PART)         0.779853         87,156         67,969         92.0	71.00 07100 MEDI CAL	SUPPLIES CHARGED TO PATIENT	S		0. 17015	8 2, 267, 064	385, 759	71.00
76.00         03950         CARDIAC REHAB         0.279163         0         0         76.0           OUTPATI ENT SERVICE COST CENTERS         0         0         0         88.0         0.279163         0         0         88.0         88.0         0.000000         0         88.0         88.0         0.000000         0         88.0         88.0         0.000000         0         88.0         88.0         9802         RURAL HEALTH CLINIC II         0.000000         0         88.0         88.0         9802         RURAL HEALTH CLINIC III         0.000000         0         88.0         98.0         91.00         0.9100         EMERGENCY         0.139970         2, 181,609         305,360         91.0         92.00         09200         0BSERVATION BEDS (NON-DI STINCT PART)         0.779853         87,156         67,969         92.0					0. 32390	2 5, 749, 883	1, 862, 399	72.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0.000000         0         88.0           88.01         08801         RURAL HEALTH CLINIC         0.000000         0         88.0           88.02         08802         RURAL HEALTH CLINIC II         0.000000         0         88.0           88.02         08802         RURAL HEALTH CLINIC III         0.000000         0         88.0           91.00         09100         EMERGENCY         0.139970         2, 181, 609         305, 360         91.0           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         0.779853         87, 156         67, 969         92.0							1, 413, 803	
88. 00         08800         RURAL         HEALTH         CLINIC         0         88. 0         88. 0           88. 01         08801         RURAL         HEALTH         CLINIC         0         0.000000         0         88. 0           88. 02         08802         RURAL         HEALTH         CLINIC         0         0.000000         0         88. 0           91. 00         09100         EMERGENCY         0.139970         2, 181, 609         305, 360         91. 0           92. 00         09200         OBSERVATION         BEDS         (NON-DI STINCT PART)         0.779853         87, 156         67, 969         92. 0					0. 27916	3 0	0	76.00
88. 01         08801         RURAL         HEALTH         CLINICII         88. 0         88. 0           88. 02         08802         RURAL         HEALTH         CLINICIII         0         000000         0         88. 0           91. 00         09100         EMERGENCY         0. 139970         2, 181, 609         305, 360         91. 0           92. 00         09200         OBSERVATION         BEDS         (NON-DI STINCT PART)         0. 779853         87, 156         67, 969         92. 0								
88. 02         08802         RURAL         HEALTH         CLINICIII         0         88. 0         91. 0         91. 0         91. 0         91. 0         91. 0         92. 0         92. 0         0. 30970         2, 181, 609         305, 360         91. 0         92. 0         92. 0         0. 779853         87, 156         67, 969         92. 0         92. 0							-	
91.00         09100         EMERGENCY         0.139970         2,181,609         305,360         91.0           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0.779853         87,156         67,969         92.0							-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 779853 87, 156 67, 969 92. 0							-	
200 001  Total (sum of lines 50 through 94 and 96 through 98)   26 013 719  6 899 306/200 0					0. 77985			
						26, 013, 719	6, 899, 306	
				ine 61)		0		201.00
202.00         Net charges (line 200 minus line 201)         26,013,719         202.0	202.00   Net cha	arges (line 200 minus line 20	1)			26, 013, 719		202.00

Health Financial Systems HENRY COUNTY MEM				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0030	Period: From 01/01/2020	Worksheet D-3	3
			To 12/31/2020		pared.
			10 12/01/2020	7/30/2021 9:1	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDIATRICS			224, 897		30.00
31. 00 03100 INTENSIVE CARE UNIT			110, 767		31.00
43. 00 04300 NURSERY			241, 315		43.00
ANCI LLARY SERVI CE COST CENTERS		0.05.00		(0.0/0	
50. 00 05000 OPERATI NG ROOM		0. 25498			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 1883	-	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 24404		7, 228	
57. 00 05700 CT SCAN		0.02729			
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0.05612		783	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
		0. 18749		41, 810	
60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY		0.0000		0	
		0.34259		21, 656	
		1.0099 0.5777			
67.00 06700 0CCUPATI 0NAL THERAPY 68.00 06800 SPEECH PATHOLOGY		0. 5777			
69. 00  06900  SPEECH PATHOLOGY 69. 00  06900  ELECTROCARDI OLOGY		0. 07450			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0895		36, 169	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 32390		0	
73. 00 07300 DRUGS CHARGED TO PATTENTS		0. 32390		51, 152	
76. 00 03950 CARDI AC REHAB		0. 27910			
OUTPATIENT SERVICE COST CENTERS		0.27910	470	155	70.00
88. 00 08800 RURAL HEALTH CLINIC		2. 23439	97 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II		1. 1106		0	
88. 02 08802 RURAL HEALTH CLINIC III		1. 7595		0	
91. 00 09100 EMERGENCY		0, 13928		16, 958	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7798		0, 458	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.7790	1, 114, 143		
201.00 Less PBP Clinic Laboratory Services-Program only char	nes (line 61)		1, 114, 145	230,793	200.00
202.00 Net charges (line 200 minus line 201)			1, 114, 143		201.00
		I	1,117,143	I	1202.00

	Financial Systems HENRY COUNTY MEMORIAL H ATION OF REIMBURSEMENT SETTLEMENT Prov	vi der CCN: 15-0030	Peri od: From 01/01/2020 To 12/31/2020	u of Form CMS-2 Worksheet E Part A Date/Time Pre 7/30/2021 9:1	pared:
		Title XVIII	Hospi tal	PPS	1
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring p	prior to October 1	(see	0 5, 393, 433	
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring ( instructions)	on or after October	1 (see	2, 024, 758	1.02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for di 1 (see instructions)	scharges occurring	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for di October 1 (see instructions)	scharges occurring	on or after	0	1.04
2.00	Outlier payments for discharges. (see instructions)			0	2.00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions)	1		0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see			33, 989	-
2.00	Outlier payments for discharges occurring on or after October 1 (see			5, 748	•
3.00	Managed Care Simulated Payments	,		0	3.00
4.00	Bed days available divided by number of days in the cost reporting	g period (see instr	uctions)	45.45	4.00
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most red	cent cost reporting	period ending on	0.00	5.00
0.00	or before 12/31/1996. (see instructions)	some obset i opor ening	por ou ondring on	01.00	0.00
6.00	FTE count for allopathic and osteopathic programs that meet the cu new programs in accordance with 42 CFR 413.79(e)	riteria for an add-	on to the cap for	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under			0.00	•
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 ( cost report straddles July 1, 2011 then see instructions.	CFR §412.105(f)(1)(	iv)(B)(2)	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c) 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8. 01	The amount of increase if the hospital was awarded FTE cap slots u report straddles July 1, 2011, see instructions.	under§5503 of the	ACA. If the cost	0.00	8.01
8. 02	The amount of increase if the hospital was awarded FTE cap slots under § 5506 of ACA. (see instructions)	from a closed teach	ing hospital	0.00	8. 02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8 instructions)	3, 8,01 and 8,02)	(see	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current	year from your reco	rds	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	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year en otherwise enter zero.	nded on or after Se	ptember 30, 1997,	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
	Adjustment for residents in initial years of the program				16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	•
18.00	Adjusted rolling average FTE count			0.00	•
	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)			0.000000 0.000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions)			0.000000	
	IME payment adjustment - Managed Care (see instructions)			0	
23.00	Indirect Medical Education Adjustment for the Add-on for § 422 of Number of additional allopathic and osteopathic IME FTE resident of		CFR 412.105	0.00	23.00
	(f)(1)(iv)(C)				
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	
	If the amount on line 24 is greater than -O-, then enter the lower instructions)	r of line 23 or lin	e 24 (see	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.00000	1
	IME payments adjustment factor. (see instructions)			0.000000	•
	IME add-on adjustment amount (see instructions)			0	
	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment ( sum of lines 22 and 28)			0	
	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	•
30.00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patien	t days (see instru	ctions)	3. 97	30.00
	Percentage of Medicaid patient days (see instructions)	it days (see institu		21.66	•
	Sum of Lines 30 and 31				32.00
33.00	Allowable disproportionate share percentage (see instructions)			10.36	1
	Disproportionate share adjustment (see instructions)				34.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period:	u of Form CMS-2 Worksheet E	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	
		T:		7/30/2021 9:1	5 an
		Title XVIII	Hospital	PPS	
			Prior to 10/1 1.00	2.00	-
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)		0	0	
	Factor 3 (see instructions)		0. 00000000	0.00000000	
5. 02	Hospital uncompensated care payment (If line 34 is zero, en	iter zero on this line) (se	e 476, 271	444, 600	35
	instructions)		05/ 550	110.0/1	0.5
	Pro rata share of the hospital uncompensated care payment a		356, 553	112, 064	
. 00	Total uncompensated care (sum of columns 1 and 2 on line 35 Additional payment for high percentage of ESRD beneficiary of		468, 617		36
). 00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683,		0		40
. 00	instructions)	004 and 005. (See	0		40
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683 684 an 685 (see	0		41
	instructions)		-		
I. 01	Total ESRD Medicare covered and paid discharges excluding M	IS-DRGs 652, 682, 683, 684	0		41
	an 685. (see instructions)				
	Divide line 41 by line 40 (if less than 10%, you do not qua		0.00		42
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,	682, 683, 684 an 685. (see	0		43
	instructions)				
1.00	Ratio of average length of stay to one week (line 43 divide	ed by line 41 divided by 7	0. 000000		44
- 00	days) Average weekly cost for dialycic treatments (see instruction	ne)	0.00		45
5.00	Average weekly cost for dialysis treatments (see instructio Total additional payment (line 45 times line 44 times line		0.00		40
. 00 . 00	Subtotal (see instructions)	41.01)	8, 118, 676		40
	Hospital specific payments (to be completed by SCH and MDH,	small rural bospitals	9, 431, 471		48
	only. (see instructions)		, 101, 171		
				Amount	
				1.00	
9.00				9, 103, 272	
	Payment for inpatient program capital (from Wkst. L, Pt. I			582, 298	
	Exception payment for inpatient program capital (Wkst. L, P			0	
	Direct graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment	TTHE 49 SEE THSTRUCTIONS).		0	
	Special add-on payments for new technologies			0	
4.01	Islet isolation add-on payment			0	-
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	
5.00	<b>o</b>	-		0	
	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35).	0	
	Ancillary service other pass through costs from Wkst. D, Pt		0 ,	0	58
9.00	Total (sum of amounts on lines 49 through 58)			9, 685, 570	59
0. 00	Primary payer payments			0	
	Total amount payable for program beneficiaries (line 59 min	nus line 60)		9, 685, 570	
	Deductibles billed to program beneficiaries			861, 300	
3.00	1 0			2, 816	
4.00	Allowable bad debts (see instructions)			50, 090	
	Adjusted reimbursable bad debts (see instructions)	(atructions)		32, 559	
	Allowable bad debts for dual eligible beneficiaries (see in	istructions)		33,858	
	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo	nr annlicable to MS_DPCs (s	ee instructione)	8, 854, 013 0	
	Outlier payments reconciliation (sum of lines 93, 95 and 96			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		-,	0	
	Rural Community Hospital Demonstration Project (§410A Demon	stration) adjustment (see	instructions)	0	
	Demonstration payment adjustment amount before sequestratio			0	
). 88	SCH or MDH volume decrease adjustment (contractor use only)			0	
	Pioneer ACO demonstration payment adjustment amount (see in				70
	HSP bonus payment HVBP adjustment amount (see instructions)			-1, 666	
	HSP bonus payment HRR adjustment amount (see instructions)			-13, 543	
				0	70
0. 91	Bundled Model 1 discount amount (see instructions)				
0. 91 0. 92 0. 93	HVBP payment adjustment amount (see instructions)			-11, 364	
). 91 ). 92 ). 93 ). 94	. , ,			-105, 508	

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CO		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
), 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0 2020	1.00 755,064	70. 9
0	the corresponding federal year for the period prior to 10/1)			2020	755,004	70
). 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		2021	301, 642	70. 9
	the corresponding federal year for the period ending on or af	fter 10/1)				
). 98 ). 99	Low Volume Payment-3				0	70. 9 70. 9
. 00	HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			9, 778, 638	
. 01	Sequestration adjustment (see instructions)	o, a ,o,			64, 539	
. 02	Demonstration payment adjustment amount after sequestration				0	71.(
. 03	Sequestration adjustment-PARHM pass-throughs					71.(
2.00	Interim payments				9, 721, 732	
2. 01 8. 00	Interim payments-PARHM Tentative settlement (for contractor use only)				0	72. ( 73. (
3. 00 3. 01	Tentative settlement-PARHM (for contractor use only)				0	73.0
. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0	)2, 72, and			-7,633	
	73)					
. 01	Balance due provider/program-PARHM (see instructions)					74.(
5.00	Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	nce with			206, 938	75.0
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.
	plus 2.04 (see instructions)					
. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.
. 00	Operating outlier reconciliation adjustment amount (see instr				0	92.
. 00	Capital outlier reconciliation adjustment amount (see instruc The rate used to calculate the time value of money (see instr				0 0.00	93. 94.
5.00	Time value of money for operating expenses (see instructions)				0.00	95.
. 00					0	96.
				Prior to 10/1		
	USD Depuis Depument Amount			1.00	2.00	
0 00	HSP Bonus Payment Amount HSP bonus amount (see instructions)			737, 102	247, 494	100
	HVBP Adjustment for HSP Bonus Payment			707,102	217,171	100.
)1. OC	HVBP adjustment factor (see instructions)			0.9964299598	1.0038973054	101.
2.00	HVBP adjustment amount for HSP bonus payment (see instruction	ıs)		-2, 631	965	102.
	HRR Adjustment for HSP Bonus Payment			0.0017	0.0700	100
	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions	.)		0. 9917 -6, 118	0. 9700 -7, 425	
74. UC	Rural Community Hospital Demonstration Project (§410A Demonst	ration) Adiu	ustment	-0, 110	-7,423	104.
0. 00	Is this the first year of the current 5-year demonstration pe					200.
	Century Cures Act? Enter "Y" for yes or "N" for no.					
	Cost Reimbursement	(0)				
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	ne 49)				201. 202.
	Medicare discharges (see instructions)					202. 203.
2.00	Case_mix adjustment factor (see instructions)			nt 5-vear demons	tration	205.
2.00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first vear	of the curre			
2.00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	ı first year	of the curre	ant 5-year demons		204.
02.00 03.00	Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	ı first year	of the curre			
02.00 03.00 04.00	Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)		of the curre			205.
02.00 03.00 04.00	Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)		of the curre			
02.00 03.00 04.00 05.00 06.00	Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement		of the curre			205. 206.
2.00 3.00 4.00 5.00 6.00	Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	ructions)	of the curre			205. 206. 207.
02.00 03.00 04.00 05.00 06.00 07.00 08.00	Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	ructions)	of the curre			205. 206.
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	ructions)	of the curre			205. 206. 207. 208. 209.
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ructions) line 59)	of the curre			205. 206. 207. 208. 209. 210.
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00	Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ructions) line 59)	of the curre			205. 206. 207. 208. 209. 210. 211.
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00	Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare PPS Reimbursement Total adjustment to Medicare Part A IPPS payments (see instructions)	ructions) line 59)	of the curre			205. 206. 207. 208. 209. 210. 211. 212.
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 1. 00 2. 00 3. 00	Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ructions) line 59) 211)				205. 206. 207. 208. 209. 210. 211.

ov wc	Financial Systems LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2020 To 12/31/2020		pared
		W/S E, Part A line	Amounts (from E, Part A)	Title Pre/Post Entitlement	XVIII Period Prior to 10/01	Hospi tal Peri od On/After 10/01	PPS Total (Col 2 through 4)	
00		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier payments	1.00	0	0		0 0	0	1.0
01	DRG amounts other than outlier payments for discharges	1.01	5, 393, 433	0	5, 393, 43	3	5, 393, 433	1.(
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1.02	2, 024, 758	0		2, 024, 758	2, 024, 758	1. (
03	1 DRG for Federal specific operating payment for Model 4 BPCL occurring prior to	1.03	0	0		0	0	1. (
04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1. (
00	Outlier payments for	2.00						2.0
0.1	discharges (see instructions)	0.00		0			0	
01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0 0	0	2.0
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	33, 989	0	33, 98	9	33, 989	2.0
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	5, 748	0		5, 748	5, 748	2.
00	Operating outlier	2. 01	0	0		0 0	0	3.0
00	reconciliation Managed care simulated payments	3.00	0	0		0 0	0	4.
	Indirect Medical Education Adju				1			
00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0. 00000	0 0. 000000		5.
00	IME payment adjustment (see instructions)	22.00	0	0		o o	0	6.
01	IME payment adjustment for managed care (see	22.01	0	0		0 0	0	6.
	instructions) Indirect Medical Education Adju	istment for th	e Add-on for Se	ection 422 of	the MMA			-
00	IME payment adjustment factor	27.00	0. 000000			0 0. 000000		7.
00	(see instructions) IME adjustment (see	28.00	0	0		0 0	0	8.
01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	0		0 0	0	8.
00	instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0		0 0	0	9.
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	Ο	0		0 0	0	9.
	Disproportionate Share Adjustme	ent			1			1
	Allowable disproportionate share percentage (see instructions)	33.00	0. 1036	0. 1036	0. 103	6 0. 1036		10.
. 00	Disproportionate share adjustment (see instructions)	34.00	192, 131	0	139, 69	0 52, 441	192, 131	11.
. 01	Uncompensated care payments	36.00	468, 617	0	356, 55	3 112, 064	468, 617	11.
	Additional payment for high per	centage of ES	RD beneficiary	di scharges				
. 00	Total ESRD additional payment (see instructions)	46.00	0	0		0 0	0	12.
. 00 . 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47.00 48.00	8, 118, 676 9, 431, 471	0 0			8, 118, 676 9, 431, 471	
. 00	(see instructions) Total payment for inpatient operating costs (see	49.00	9, 103, 272	0	6, 622, 19	7 2, 481, 075	9, 103, 272	15.

LOW VO	LUME CALCULATION EXHIBIT 4			Provider C	CN: 15-0030	Period: From 01/01/2020 To 12/31/2020		epared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prio to 10/01	r Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4,00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	582, 298	0			582, 298	3 16.00
17.00	Special add-on payments for new technologies	54.00	0	0		0 0	C	
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	C	17.01 17.02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	C	18.00
19.00	SUBTOTAL			0	7, 048, 6	2, 636, 871	9, 685, 570	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		577, 163 0	0	427, 08	83 150, 080 0 0	577, 163 0	
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2.00 2.01	5, 135 0	0 0	-58	81 5, 716 0 0	5, 135 0	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.000	0.000 0.		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	C	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	O	
26.00	Total prospective capital payments (see instructions)	12.00	582, 298	0	426, 50	02 155, 796	582, 298	3 26.00
		W/S E, Part A						
		line 0	<u>E, Part A)</u> 1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor		1.00	2.00	0, 1071;		5.00	27.00
28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			755, 00		755, 064	
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A. Line)	70. 97				301, 642	301, 642	29.00
100. 00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

SPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2020 To 12/31/2020	Date/Time Prep 7/30/2021 9:1	pared
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt.	Period to 10/01	Hospital Period on after 10/01	PPS Total (cols. 2 and 3)	
		0	A) 1.00	2.00	3.00	4.00	
00	DRG amounts other than outlier payments	1.00	1.00	2.00	3.00	4.00	1.0
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5, 393, 433	5, 393, 43	3	5, 393, 433	1.0
02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	2, 024, 758		2, 024, 758	2, 024, 758	1.(
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1. (
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1.04	0		0	0	1. (
00	October 1 Outlier payments for discharges (see instructions)	2.00					2.0
01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0 0	0	2. (
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	33, 989	33, 98	9	33, 989	2.
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	5, 748		5, 748	5, 748	2.
00 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0		0 0 0 0	0	3. 4.
50	Indirect Medical Education Adjustment	3.00	۹ ۱		0	0	ч.
00	Amount from Worksheet E, Part A, Line 21 (see instructions)	21.00	0. 000000	0.00000	0 0.000000		5.
00 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22. 00 22. 01	0 0		0 0 0 0	0 0	6. 6.
	Indirect Medical Education Adjustment for the	e Add-on for S	ection 422 of t	he MMA			
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 00000	0 0.000000		7.
00	IME adjustment (see instructions)	28.00	0		0 0	0	8.
)1	IME payment adjustment add on for managed care (see instructions)	28. 01	0		0 0	0	8.
)0 )1	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 00 29. 01	0 0		0 0 0 0	0 0	9. 9.
	Disproportionate Share Adjustment		1 1				
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1036	0. 103	. 6 0. 1036		10.
00	Disproportionate share adjustment (see instructions)	34.00	192, 131	139, 69	0 52, 441	192, 131	11.
01	Uncompensated care payments Additional payment for high percentage of ESI	36.00 RD beneficiary	468, 617 di scharges	356, 55	3 112, 064	468, 617	11.
00		46.00	0		0 0	0	12.
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	8, 118, 676 9, 431, 471	5, 923, 66	5 2, 195, 011 0 0	8, 118, 676 0	13. 14.
00	instructions) Total payment for inpatient operating costs	49.00	9, 103, 272	6, 908, 26	1 2, 195, 011	9, 103, 272	15.
00	(see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	582, 298	-150, 66	732, 959	582, 298	16.
00 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	0		0 0	0	17. 17.
02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.
00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.
	SUBTOTAL		1	6, 757, 60	0 2, 927, 970		

		ENRY COUNTY MEN				u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	577, 163	-150, 08	0 727, 243	577, 163	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	5, 135	-58	1 5, 716	5, 135	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 0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0.0000	0.000	0 0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	582, 298	-150, 66	1 732, 959	582, 298	26.00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70. 96	755, 064	755, 06	4	755, 064	28.00
29.00	Low volume adjustment on or after October 1	70. 97	301, 642		301, 642	301, 642	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	-11, 364	-19, 25	5 7, 891	-11, 364	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	-1, 666	-2, 63	1 965	-1, 666	30. 01
31.00	HRR adjustment (see instructions)	70, 94	-105, 508	-44, 76	5 -60, 743	-105, 508	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	-13, 543				
	· · · · · · · · · · · · · · · · · · ·					(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Ν				100. 00

	FION OF REIMBURSEMENT SETTLEMENT	F	eriod: rom 01/01/2020	Worksheet E	
			b 12/31/2020	Part B Date/Time Pre 7/30/2021 9:1	
		Title XVIII	Hospi tal	PPS	
				1.00	
P/	ART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	<u> </u>
1.00 M	ledical and other services (see instructions)			641	1.00
	ledical and other services reimbursed under OPPS (see instruc	tions)		9, 610, 891	2.00 3.00
	IPPS payments Nutlier payment (see instructions)			8, 437, 738 8, 029	4.00
4.01 0	utlier reconciliation amount (see instructions)			0	4.01
	inter the hospital specific payment to cost ratio (see instru	ctions)		0.000	
	ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6			0 0.00	
8.00 T	ransitional corridor payment (see instructions)			0	
	ncillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
	ngan acquisitions otal cost (sum of lines 1 and 10) (see instructions)			0 641	10.00
	OMPUTATION OF LESSER OF COST OR CHARGES			011	
	easonable charges			1 710	10.00
	ncillary service charges Irgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		1, 718 0	12.00 13.00
	otal reasonable charges (sum of lines 12 and 13)			-	14.00
	ustomary charges				15.00
	ggregate amount actually collected from patients liable for mounts that would have been realized from patients liable fo			0	15.00
	ad such payment been made in accordance with 42 CFR §413.13(		a chargebasi s	0	10.00
	atio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	otal customary charges (see instructions) xcess of customary charges over reasonable cost (complete on	lvifline 18 exceeds line	) 11) (see	1, 718 1, 077	
	nstructions)	ry II IIIe Io exceeds IIIk	(366	1,077	17.00
	xcess of reasonable cost over customary charges (complete on	ly if line 11 exceeds line	e 18) (see	0	20.00
	nstructions) esser of cost or charges (see instructions)			641	21.00
	nterns and residents (see instructions)			0	
	ost of physicians' services in a teaching hospital (see inst	ructions)		0	23.00
	otal prospective payment (sum of lines 3, 4, 4.01, 8 and 9) OMPUTATION OF REIMBURSEMENT SETTLEMENT			8, 445, 767	24.00
	eductibles and coinsurance amounts (for CAH, see instruction	s)		4	25.00
	eductibles and Coinsurance amounts relating to amount on lin			1, 423, 415	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) nstructions)	plus the sum of lines 22 a	and 23] (see	7,022,989	27.00
	irect graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28.00
	SRD direct medical education costs (from Wkst. E-4, line 36)			0	
	ubtotal (sum of lines 27 through 29) rimary payer payments			7, 022, 989 1, 208	
31.00 F 32.00 S	ubtotal (line 30 minus line 31)			7, 021, 781	
AI	LLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	omposite rate ESRD (from Wkst. I-5, line 11) Ilowable bad debts (see instructions)			0 195, 997	
	djusted reimbursable bad debts (see instructions)			127, 398	
	llowable bad debts for dual eligible beneficiaries (see inst	ructions)		175, 684	
	ubtotal (see instructions) ISP-LCC reconciliation amount from PS&R			7, 149, 179 -75	1
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			- / 5	
39.50 P	ioneer ACO demonstration payment adjustment (see instruction	s)			39.50
1	emonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla	cod dovi cos (soo i pstructi	onc)	0	
	ECOVERY OF ACCELERATED DEPRECIATION		UIS)	0	39.99
40.00 S	ubtotal (see instructions)			7, 149, 254	40.00
	equestration adjustment (see instructions)			47, 185	
	emonstration payment adjustment amount after sequestration equestration			0	40.02
41.00 I	nterim payments			7, 162, 565	41.00
1	nterim payments-PARHM				41.01
	entative settlement (for contractors use only) entative settlement-PARHM (for contractor use only)			0	42.00
43.00 B	alance due provider/program (see instructions)			-60, 496	43.00
	al ance due provider/program-PARHM (see instructions)			_	43.01
	rotested amounts (nonallowable cost report items) in accorda 115.2	nce with CMS Pub. 15-2, cl	apter 1,	0	44.00
	0 BE COMPLETED BY CONTRACTOR				
90.00 0	riginal outlier amount (see instructions)			0	
	Nutlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	
	ime Value of Money (see instructions)			0.00	
94.00 T	otal (sum of lines 91 and 93)			0	94.00

ANALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2020 To 12/31/2020		pared:
			XVIII	Hospi tal	PPS	
		Inpati 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 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		9, 721, 73	32 0	6, 984, 505 0	1.00 2.00 3.00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0 12/31/2020	178, 060	3.01
3.02				0	0	3.02
3. 03 3. 04				0	0	3.03
3.04				0	0	3.02
0.00	Provider to Program					0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52 3.53				0	0	3.52 3.52
3.53				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	178, 060	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9, 721, 73	32	7, 162, 565	4.00
- 00	TO BE COMPLETED BY CONTRACTOR					FO
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider			-	-	
5. 01 5. 02	TENTATI VE TO PROVI DER			0	0	5.01 5.02
5.02				0	0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM			0	0	5.50
5. 51 5. 52				0	0	5.5 5.52
5.52 5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.5. 5.9
5.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
5. 01	SETTLEMENT TO PROVIDER			0	0	6.0
5.02	SETTLEMENT TO PROGRAM		7,63		60, 496	6.0
7.00	Total Medicare program liability (see instructions)		9, 714, 09	Contractor	7, 102, 069 NPR Date	7.0
				Number	(Mo/Day/Yr)	
		C	1	1.00	2.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT       Provider CCN: 15-0030       Period: From 01/01/2020 To 12/31/2020       Worksheet E-1 Part II Date/Time Prep 7/30/2021 9:15         To be completed by contractor for Nonstandard cost reports HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION       1.00         1.00       Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14	
To 12/31/2020 Date/Time Prep 7/30/2021 9:15 Title XVIII Hospital PPS Title XVIII Hospital PPS 1.00 TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
Title XVIII Hospital PPS Title XVIII Hospital PPS To be completed by contractor for nonstandard cost reports HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	arod
Title XVIII     Hospital     PPS       1.00       TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS       HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
1 00 Total bosnital discharges as defined in AARA \$4102 from West S_3 Pt 1 col 15 line 14	
	1.00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3.00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I	7.00
line 168	
8.00 Calculation of the HIT incentive payment (see instructions)	8.00
9.00 Sequestration adjustment amount (see instructions)	9.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	
30.00 Initial/interim HIT payment adjustment (see instructions)	30.00
31.00 Other Adjustment (specify)	31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Peri od:	Worksheet E-3	2552 }
			From 01/01/2020 To 12/31/2020		
		Title XIX	Hospi tal	Cost	D all
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	ERVICES FOR TITLES V OR	XIX SERVICES		-
00	COMPUTATION OF NET COST OF COVERED SERVICES		(04.000		
00 00	Inpatient hospital/SNF/NF services		604, 992	0	1.
00	Medical and other services Organ acquisition (certified transplant centers only)		0	0	3
00	Subtotal (sum of lines 1, 2 and 3)		604, 992	0	
00	Inpatient primary payer payments		0	Ū	5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		604, 992	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
00	Routine service charges		576, 979		8
00 ). 00	Ancillary service charges		1, 114, 143	0	9
I. 00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		11
2.00	Total reasonable charges (sum of lines 8 through 11)		1, 691, 122	0	
. 00	CUSTOMARY CHARGES		1,071,122	0	1 12
3.00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	13
	basi s				
1.00	Amounts that would have been realized from patients liable for	or payment for services	on 0	0	14
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
5.00	Total customary charges (see instructions)		1, 691, 122	0	
7.00	Excess of customary charges over reasonable cost (complete or	nly if line 16 exceeds	1, 086, 130	0	17
3. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete or	nly if line 4 exceeds li	no 0	0	18
5.00	16) (see instructions)	In y 11 1111e 4 exceeds 11	0	0	
9.00	Interns and Residents (see instructions)		0	0	19
0. 00	Cost of physicians' services in a teaching hospital (see inst	tructions)	0	0	20
1.00	Cost of covered services (enter the lesser of line 4 or line		604, 992	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	e completed for PPS prov	iders.		
	Other than outlier payments		0	0	
3.00	Outlier payments		0	0	
	Program capital payments		0		24
	Capital exception payments (see instructions)		0	0	25
5.00 7.00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	
3.00	Customary charges (title V or XIX PPS covered services only)		0	0	
7.00 7.00	Titles V or XIX (sum of lines 21 and 27)		604, 992	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		001,772	<u> </u>	1 - 1
0. 00	Excess of reasonable cost (from line 18)		0	0	30
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	6)	604, 992	0	31
2.00	Deducti bl es		0	0	
3.00	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35
b. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 ar	nd 33)	604, 992	0	
7.00 3.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37)		0 604, 992	0	
	Direct graduate medical education payments (from Wkst. E-4)		004, 992	0	39
9.00 D.00	Total amount payable to the provider (sum of lines 38 and 39)	)	604, 992	0	
	Interim payments	,	711, 687	0	
2.00	Balance due provider/program (line 40 minus line 41)		-106, 695	0	
	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2,	0	0	
	chapter 1, §115.2				1

	E SHEET (If you are nonproprietary and do not maintain sype accounting records, complete the General Fund column	Provider C	F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet G Date/Time Pre 7/30/2021 9:1	pare
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	+
. 00	Cash on hand in banks	24, 070, 139	C	0	0	1.
. 00	Temporary investments	0	0	0	0	
. 00	Notes receivable	0	C	0	0	3.
00	Accounts receivable	16, 139, 274	0	0	0	4
00	Other receivable	0	0	0	0	5
00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6
00	Inventory	1, 158, 678		-	0	
00	Prepaid expenses	1, 213, 333	0	Ű	0	
00	Other current assets	6, 474, 558		-	0	
). 00 I. 00	Due from other funds	61, 489, 581		-	0	
. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	110, 545, 563	<u> </u>	0	0	1''
2.00	Land	46,000	C	0	0	12
3.00	Land improvements	2, 112, 571			0	
	Accumulated depreciation	-1, 584, 757			0	
	Bui I di ngs	42,082,284	c c	0	0	
6.00	Accumulated depreciation	-32, 692, 464	c c	0	0	16
7.00	Leasehold improvements	1, 898, 222	0	0	0	17
3.00	Accumulated depreciation	-1, 098, 674	C	0	0	18
	Fixed equipment	22, 759, 639	C	0	0	19
	Accumulated depreciation	-13, 029, 351	0	-	0	
	Automobiles and trucks	0	C	Ű	0	
	Accumulated depreciation	0	0	-	0	
	Major movable equipment	38, 261, 372	0	Ű	0	
	Accumulated depreciation	-23, 901, 050		-	0	
	Minor equipment depreciable Accumulated depreciation	0		Ű	0	
	HIT designated Assets	0		Ű	0	
	Accumulated depreciation	0		-	0	
	Mi nor equi pment-nondepreci abl e	0		-	0	
	Total fixed assets (sum of lines 12-29)	34, 853, 792			0	
	OTHER ASSETS		-	-	-	1
1.00	Investments	12, 900, 936	0	0	0	31
2.00	Deposits on Leases	0	0	0	0	32
3.00	Due from owners/officers	0	C	0	0	33
4.00	Other assets	7, 772, 370		-	0	
	Total other assets (sum of lines 31-34)	20, 673, 306			0	
6.00	Total assets (sum of lines 11, 30, and 35)	166, 072, 661	0	0	0	36
- 00	CURRENT LI ABI LI TI ES	E 0E2 220			0	1
	Accounts payable Salaries, wages, and fees payable	5, 952, 330 6, 324, 114			0	
<i>7.</i> 00	Payrol I taxes payable	0, 324, 114			0	
	Notes and Loans payable (short term)	1, 366, 037			0	
	Deferred income	1,000,007		0	0	
	Accel erated payments	0			-	42
3.00	Due to other funds	56, 137, 769	c d	0	0	
4.00	Other current liabilities	2, 406, 976	0	0	0	44
5.00	Total current liabilities (sum of lines 37 thru 44)	72, 187, 226	0	0	0	45
	LONG TERM LIABILITIES					
	Mortgage payable	0	C		0	
7.00	Notes payable	0	C	Ű	0	
	Unsecured Loans	0	0	-	0	
	Other long term liabilities	12,032,696		-	0	
	Total long term liabilities (sum of lines 46 thru 49)	12, 032, 696			0	
1.00	Total liabilities (sum of lines 45 and 50)	84, 219, 922	0	0	0	51
2.00	CAPITAL ACCOUNTS General fund balance	81, 852, 739	1	1		52
2.00 3.00	Specific purpose fund	01,002,739	l c			53
1. 00	Donor created - endowment fund balance - restricted			0		54
5.00	Donor created - endowment fund balance - unrestricted			0		55
5.00	Governing body created - endowment fund balance			0		56
7.00	Plant fund balance - invested in plant			Ĭ	0	
B. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	
	Total fund balances (sum of lines 52 thru 58)	81, 852, 739	c c	0	0	59
9.00						

Heal th	Financial Systems HE	NRY COUNTY MEMO	ORIAL HOSPITAL			In Lie	u of Form CMS	-2552-10
STATEM	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0030		: 1/01/2020 2/31/2020	Date/Time Pr	epared:
		General	Fund	Speci al	Purpose	Fund	7/30/2021 9: Endowment Fund	15 am
		1.00	2.00	3.00		4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	77, 124, 108 4, 728, 631 81, 852, 739 0 81, 852, 739 0 81, 852, 739		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0		1.00           2.00           3.00           4.00           5.00           6.00           7.00           0.8.00           9.00           10.00           11.00           12.00           13.00           0.14.00           0.15.00           14.00           15.00           16.00           17.00           18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	Endowment Fund	81, 852, 739 Pl ant	Fund		0		19.00
		6. 00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0 0	0.00	0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0		0 0 0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

ΓΑΤΕΜ	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0030	Period: From 01/0 To 12/3	01/2020 31/2020	Worksheet G- Parts I & II Date/Time Pr 7/30/2021 9:	epare
	Cost Center Description		I npati ent	Outpa	tient	Total	
			1.00	2.0	00	3.00	
	PART I – PATIENT REVENUES						_
	General Inpatient Routine Services		1				
00	Hospi tal		11, 308, 9	39		11, 308, 939	
00	SUBPROVIDER - IPF						2.
00	SUBPROVIDER - IRF						3.
00	SUBPROVIDER						4.
00	Swing bed - SNF			0			) 5.
00	Swing bed - NF			0		(	) 6.
00	SKILLED NURSING FACILITY						7.
00	NURSI NG FACI LI TY						8.
00	OTHER LONG TERM CARE		44,000,0			11 000 000	9.
0. 00	Total general inpatient care services (sum of lines 1-9)		11, 308, 93	39		11, 308, 939	9 10.
	Intensive Care Type Inpatient Hospital Services		<b>F</b> (7 <b>F</b> (1	- 0			
1.00	I NTENSI VE CARE UNI T		5, 675, 6	52		5, 675, 652	
2.00	CORONARY CARE UNIT						12.
3.00 4.00	BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T						13.
	OTHER SPECIAL CARE (SPECIFY)						14.
5.00	Total intensive care type inpatient hospital services (sum o	flipos	5, 675, 6!	- 2		5, 675, 652	
5.00	11-15)	i iiiles	5, 075, 0	52		5, 075, 052	2 10.
7.00	Total inpatient routine care services (sum of lines 10 and 1	6)	16, 984, 59	21		16, 984, 59 <sup>-</sup>	1 17.
3.00	Ancillary services	0)	52, 670, 8		201, 129	210, 872, 024	
	Outpatient services		6, 087, 9		237, 867	48, 325, 820	
	RURAL HEALTH CLINIC		0,007,75		757,687	3, 757, 68	
	RURAL HEALTH CLINIC II				456, 386	13, 456, 386	
	RURAL HEALTH CLINIC III				759, 769	759, 769	
	FEDERALLY QUALIFIED HEALTH CENTER			0	0		21.
	HOME HEALTH AGENCY			-	529, 893	2, 629, 893	
3.00	AMBULANCE SERVICES			273	5277070	2,02,,0,0	23.
4.00	CMHC						24.
5.00	AMBULATORY SURGICAL CENTER (D. P. )						25.
5.00	HOSPI CE			0 1,5	533, 072	1, 533, 072	2 26.
7.00	NON-REI MBURSEABLE		3, 7		456, 864	11, 460, 599	
7.01	PRO FEES		2, 693, 4	65 5, <del>6</del>	540, 763	8, 334, 228	3 27.
3.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	78, 440, 6	39 239,6	573, 430	318, 114, 069	28.
	G-3, line 1)						
	PART II - OPERATING EXPENSES						_
	Operating expenses (per Wkst. A, column 3, line 200)				137, 694		29.
0.00	ADD (SPECI FY)			0			30.
1.00				0			31.
2.00				0			32.
3.00				0			33.
4.00				0			34.
5.00	Total additions (sum of lines 20.25)			0	_		35.
5.00	Total additions (sum of lines 30-35)			0	U		36.
7.00 3.00	DEDUCT (SPECI FY)			0			37.
3.00 9.00				0			38.
9.00 ).00				0			40.
1.00				0			40.
2.00	Total deductions (sum of lines 37-41)			U U	0		41.
	Total operating expenses (sum of lines 29 and 36 minus line	12) (transfor		114 -	0 137, 694		42.
3.00	to Wkst. G-3, line 4)	+z) ( ti ansi er		114,	137,094		43.

STATEN	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0030	Peri od:	Worksheet G-3	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	narod
			10 12/31/2020	7/30/2021 9:1	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir			318, 114, 069	1.00
2.00	Less contractual allowances and discounts on patients' accour	nts		218, 724, 532	2.00
3.00	Net patient revenues (line 1 minus line 2)			99, 389, 537	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		114, 137, 694	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-14, 748, 157	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			1, 456, 006	7.00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
	Revenue from laundry and linen service			0	13.00
	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other t	than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	Rental of vending machines			0	21.00
	Rental of hospital space			0	22.00
	Governmental appropriations			0	23.00
	OTHER OPERATING INCOME			5, 470, 727	
	OTHER NON-OPERATING INCOME			119, 759	
	COVI D-19 PHE Fundi ng			12, 430, 296	
	Total other income (sum of lines 6-24)			19, 476, 788	
	Total (line 5 plus line 25)			4, 728, 631	26.00
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			4, 728, 631	29.00

	Financial Systems			Provider C		Period:	u of Form CMS-2 Worksheet H	
				HHA CCN:	15-7430	From 01/01/2020 To 12/31/2020		
						Home Health Agency I	PPS	
		Sal ari es	Benefits	ransportatio n (see nstructions)	Contracted/P rchased Servi ces		Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6. 00	
00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &			0		0	0	1 1 0
. 00	Fixtures			0		0	0	1.C
. 00	Capital Related - Movable			0		0	0	2.0
. 00	Equipment Plant Operation & Maintenance	0	0	0		0 0	0	3.0
. 00	Transportati on	0	0	0		0 0	0	
. 00	Administrative and General HHA REIMBURSABLE SERVICES	134, 103	0	90, 581		0 171, 817	396, 501	5.0
. 00	Skilled Nursing Care	548, 007	0	0		0 0	548, 007	6.0
. 00	Physical Therapy	352, 702		0		0 0	352, 702	
. 00 . 00	Occupational Therapy Speech Pathology	86, 254 6, 424	0	0		0 0	86, 254 6, 424	
0.00	Medical Social Services	0, 424	0	0		0 0	0, 424	
1.00	Home Health Aide	26, 364	0	0		0 0	26, 364	
2.00	Supplies (see instructions)	0	0	0		0 0	0	
3.00 4.00	Drugs DME	0	0	0		0 0 0 0	-	
4.00	HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.
5.00	Home Dialysis Aide Services	0	0	0		0 0	0	
6.00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	
7.00 8.00	Clinic	0	0	0		0 0		
9.00	Health Promotion Activities	0	0	0		0 0	0	
D. 00	Day Care Program	0	0	0		0 0	0	
1.00	Home Delivered Meals Program	0	0	0		0 0	0	
2.00 3.00	Homemaker Service All Others (specify)	0	0	0		0 0		22. 23.
3.50	Tel emedi ci ne	0	0	0		0 0	0	23.
4.00	Total (sum of lines 1-23)	1, 153, 854	0	90, 581	Net European	0 171, 817	1, 416, 252	24.0
		Reclassificat ion	Reclassified Trial Balance	Adjustments	Net Expenses for	>		
			(col. 6 +		Allocation			
			col . 7)		(col. 8 + col. 9)			1
		7.00	8.00	9.00	10.00			-
00	GENERAL SERVICE COST CENTERS				10.00			
. 00	Capital Related - Bldg. &	7.00		9.00	10.00	0		1.0
					10.00	0		
. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment	0	0		10.00	0		2.
. 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance	0	0		10.00	0		1. 2. 3.
. 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment	0	0		10.00	0		2. 3. 4.
. 00 . 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES	0 0 0 -13, 221	0 0 0 383, 280	0 0 0 -16, 268	10. 00 367, 0			2. 3. 4. 5.
. 00 . 00 . 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care	0 0 0 0 0	0 0 0 383, 280 548, 007	0 0 0 -16, 268 0	10.00 367,0 548,00	0 0 0 12 0 7		2. 3. 4. 5. 6.
. 00 . 00 . 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES	0 0 0 -13, 221	0 0 0 383, 280	0 0 0 -16, 268	10.00 367,0 548,00	0 0 0 12 2 7 22		2. 3. 4. 5. 6. 7.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0 0 0 -13, 221	0 0 0 383, 280 548, 007 352, 702 86, 254 6, 424	0 0 0 -16, 268 0	10.00 367,0 548,00 352,7(	0 0 0 12 0 7 7 22 54		2. 3. 4. 5. 6. 7. 8. 9.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0 0 0 -13, 221	0 0 0 383, 280 548, 007 352, 702 86, 254 6, 424 0	0 0 0 -16, 268 0	10.00 367,0 548,00 352,70 86,21 6,42	0 0 0 12 0 7 22 54 24 0		2. 3. 4. 5. 6. 7. 8. 9. 10.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	0 0 0 -13, 221	0 0 0 383, 280 548, 007 352, 702 86, 254 6, 424	0 0 0 -16, 268 0	10.00 367,0 548,00 352,70 86,2	0 0 0 12 0 7 22 54 24 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00 2. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0 0 0 -13, 221	0 0 0 383, 280 548, 007 352, 702 86, 254 6, 424 0	0 0 0 -16, 268 0	10.00 367,0 548,00 352,70 86,21 6,42	0 0 0 12 0 7 22 54 24 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00 2. 00 3. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	0 0 0 -13, 221	0 0 0 383, 280 548, 007 352, 702 86, 254 6, 424 0 26, 364 0 0	0 0 0 -16, 268 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 367,0 548,00 352,70 86,29 6,4 26,30	0 0 0 12 7 7 22 54 24 0 54 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES	0 0 0 -13, 221 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 383, 280 548, 007 352, 702 86, 254 6, 424 0 26, 364 0 0 0 0	0 0 0 -16, 268 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 367,0 548,00 352,70 86,29 6,42 26,30	0 0 0 0 12 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0 0 -13, 221 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 383, 280 548, 007 352, 702 86, 254 6, 424 0 26, 364 0 0 0 0	0 0 0 -16, 268 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 367,0 548,00 352,70 86,29 6,42 26,30	0 0 0 12 0 0 12 0 0 2 54 24 0 0 54 0 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy	0 0 0 -13, 221 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 383, 280 548, 007 352, 702 86, 254 6, 424 0 26, 364 0 0 0 0	0 0 0 -16, 268 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 367,0 548,00 352,70 86,29 6,42 26,30	0 0 0 0 12 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0 0 0 -13, 221 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 383, 280 548, 007 352, 702 86, 254 6, 424 0 26, 364 0 0 0 0	0 0 0 -16, 268 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 367,0 548,00 352,70 86,29 6,42 26,30	0 0 0 0 12 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 15. 16. 17. 18.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	0 0 0 -13, 221 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 383, 280 548, 007 352, 702 86, 254 6, 424 0 26, 364 0 0 0 0	0 0 0 -16, 268 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 367,0 548,00 352,70 86,29 6,42 26,30	0 0 0 0 12 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 14. 15. 14. 15. 17. 18. 19.
. 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0 0 0 -13, 221 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 383, 280 548, 007 352, 702 86, 254 6, 424 0 26, 364 0 0 0 0	0 0 0 -16, 268 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 367,0 548,00 352,70 86,29 6,42 26,30	0 0 0 0 12 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20.
. 00 . 00 . 00 . 00 . 00 . 00 0. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 0. 00 0. 00 1. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 -13, 221 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 383, 280 548, 007 352, 702 86, 254 6, 424 0 26, 364 0 0 0 0	0 0 0 -16, 268 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 367,0 548,00 352,70 86,29 6,42 26,30	0 0 0 0 12 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21.
	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 -13, 221 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 383, 280 548, 007 352, 702 86, 254 6, 424 0 26, 364 0 0 0 0	0 0 0 -16, 268 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 367,0 548,00 352,70 86,29 6,42 26,30	0 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 3. 4. 5.

Heal th	Financial Systems	HE	NRY COUNTY MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HHA GENERAL SERVICE	E COST		Provider C	CN: 15-0030	Period: From 01/01/2020	Worksheet H-1 Part I	
				HHA CCN:	15-7430	To 12/31/2020	Date/Time Pre	epared:
						Home Health	7/30/2021 9:1 PPS	l5 am
						Agency I		
			Capital Rela	ted Costs				
		Net Expenses	BIdgs &	Movabl e	Plant	Transportatio	Subtotal	1
		for Cost	Fixtures	Equi pment	Operation &	k n	(col s. 0-4)	
		Allocation (from Wkst.			Maintenance			
		H, col. 10)						
		0	1.00	2.00	3.00	4.00	4A. 00	
1 00	GENERAL SERVICE COST CENTERS	0	0				0	1 00
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable	0		0			0	2.00
2 00	Equipment			0			0	2 00
3.00 4.00	Plant Operation & Maintenance Transportation	0	0	0		0 0	0	3.00
5.00	Admini strative and General	367, 012	0	0		0 0	367, 012	
	HHA REI MBURSABLE SERVI CES		.1		1			
6.00 7.00	Skilled Nursing Care Physical Therapy	548, 007 352, 702	0	0		0 0		
7.00 8.00	Occupational Therapy	86, 254	0	0		0 0	86, 254	
9.00	Speech Pathology	6, 424	0	0		0 0	6, 424	9.00
10.00	Medical Social Services	0	0	0		0 0	0	
11.00 12.00	Home Health Aide Supplies (see instructions)	26, 364 0	0	0			26, 364	11.00
13.00	Drugs	0	0	0		0	0	1
	DME	0	0	0		0 0	0	14.00
	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0	1	0 0	0	15.00
16.00	Respi ratory Therapy	0	0	0		0 0	-	
	Private Duty Nursing	0	Ō	0		0 0	0	
	Clinic	0	0	0		0 0	0	
	Health Promotion Activities Day Care Program	0	0	0		0 0	0	
	Home Delivered Meals Program	0	0	0		0 0	0	
22.00	Homemaker Service	0	О	0		0 0	0	
	All Others (specify)	0	0	0		0 0	0	
23.50 24.00	Telemedicine Total (sum of lines 1–23)	1, 386, 763	0	0		0 0	0 1, 386, 763	
		Administrativ	Total (cols.				.,,	
		e & General	4A + 5)					-
	GENERAL SERVICE COST CENTERS	5.00	6.00					
1.00	Capital Related - Bldg. &							1.00
	Fixtures							
2.00	Capital Related – Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	367,012						5.00
6.00	Skilled Nursing Care	197, 229	745, 236					6.00
7.00	Physi cal Therapy	126, 939	479, 641					7.00
8.00	Occupational Therapy	31,043	117, 297					8.00
9.00 10.00	Speech Pathology Medical Social Services	2, 312 0	8, 736 0					9.00
11.00	Home Heal th Ai de	9, 489	35, 853					11.00
	Supplies (see instructions)	0	0					12.00
	Drugs DME	0	0					13.00
14.00	HHA NONREI MBURSABLE SERVI CES		0					14.00
	Home Dialysis Aide Services	0	0					15.00
	Respiratory Therapy Private Duty Nursing	0	0					16.00
	Private Duty Nursing Clinic	0	0					17.00
	Health Promotion Activities	0	0					19.00
		i						20.00
19. 00 20. 00	Day Care Program	0	0					
19.00 20.00 21.00	Home Delivered Meals Program	0	0					21.00
19.00 20.00 21.00 22.00	Home Delivered Meals Program Homemaker Service	0 0 0						21.00 22.00
19.00 20.00 21.00 22.00 23.00 23.50	Home Delivered Meals Program		0 0					21.00

COST A	ALLOCATION - HHA STATISTICAL BAS	SI S		Provider C HHA CCN:	CN: 15-0030 15-7430	Period: From 01/01/2020 To 12/31/2020		pared:
						Home Health	PPS	
		Carital Dal	atad Casta			Agency I		
		Capital Rel	ated costs					
		BIdgs &	Movabl e	Plant	Transportati	o Reconciliatio	Administrativ	1
		Fixtures	Equipment	Operation &	n (MILEAGE)		e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
			VALUE)	(SQUARE FEET)				
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS	0				0		1 1 0
1.00	Capital Related - Bldg. & Fixtures	0				0		1.0
2.00	Capital Related - Movable		0			0		2.0
00	Equipment		0			0		2.0
3.00	Plant Operation & Maintenance	0	0	0		0		3.0
4.00	Transportation (see	0	0	0		0		4.0
	instructions)							
5.00	Administrative and General	0	0	0		0 -367,012	1, 019, 751	5.0
	HHA REIMBURSABLE SERVICES						<b>540.007</b>	
o. 00 7. 00	Skilled Nursing Care Physical Therapy	0	0	0		0 0	548, 007 352, 702	
3.00	Occupational Therapy	0	0	0		0 0	352, 702 86, 254	
. 00	Speech Pathol ogy	0	0				6, 424	
0.00	Medical Social Services	0	0	0		0 0	0, 424	
1.00	Home Heal th Ai de	0	0	0		0 0	26, 364	
2.00	Supplies (see instructions)	0	0	0		0 0	0	12. (
3.00	Drugs	0	0	0		0	0	13.0
4.00	DME	0	0	0		0 0	0	14.(
	HHA NONREI MBURSABLE SERVI CES						-	
5.00	Home Dialysis Aide Services	0	0	0		0 0	0	-
6.00 7.00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0				0	
9.00	Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	
1.00	Home Delivered Meals Program	0	0	0		0 0	0	21.0
2.00	Homemaker Service	0	0	0		0 0	0	22.0
3.00	All Others (specify)	0	0	0		0 0	0	
3.50	Tel emedi ci ne	0	0	0		0 0	0	
4.00	Total (sum of lines 1-23)	0	0	0		0 -367,012	1, 019, 751	
25.00	Cost To Be Allocated (per	0	0	0		U	367, 012	25.0
26 00	Worksheet H-1, Part I) Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 00000	00	0. 359904	26 1
.0.00		0.000000	0.000000	0.00000	I 0.0000		0. 337704	I ∠0.

Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS T		NRY COUNTY MEM	Provi der C		Peri od:	u of Form CMS-2 Worksheet H-2	
			HHA CCN:	15-7430	From 01/01/2020 To 12/31/2020	Part I Date/Time Pre 7/30/2021 9:1	pared:
					Home Health Agency I	PPS	
		CAPI TAL REL	ATED COSTS		Ageney 1		
Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	
	0	1.00	2.00	4.00	4A	5.00	
1.00Administrative and General2.00Skilled Nursing Care3.00Physical Therapy4.00Occupational Therapy5.00Speech Pathology6.00Medical Social Services7.00Home Health Aide8.00Supplies (see instructions)9.00Drugs10.00DME11.00Home Dialysis Aide Services12.00Respiratory Therapy13.00Private Duty Nursing14.00Clinic15.00Health Promotion Activities16.00Day Care Program17.00Home Delivered Meals Program18.00Hothers (specify)19.50Telemedicine20.00Total (sum of lines 1-19) (2)21.00Unit Cost Multiplier: column26, line 1 divided by the sumof column 26, line 20 minuscolumn 26, line 1, rounded to	0 745, 236 479, 641 117, 297 8, 736 0 35, 853 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	375, 56	$ \begin{array}{cccccccccccccccccccccccccccccccccccc$	73, 882 146, 606 94, 357 23, 075 1, 719 0 7, 053 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ \end{array}$
6 decimal places. Cost Center Description	OPERATI ON OF PLANT	LAUNDRY & LI NEN SERVI CE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	
	7.00	8.00	9.00	10.00	11.00	N 13.00	
<ol> <li>Administrative and General</li> <li>O Skilled Nursing Care</li> <li>O Physical Therapy</li> <li>O Occupational Therapy</li> <li>O Occupational Therapy</li> <li>O Speech Pathology</li> <li>O Medical Social Services</li> <li>O Home Health Aide</li> <li>O Supplies (see instructions)</li> <li>O Drugs</li> <li>O DME</li> <li>O Respiratory Therapy</li> <li>O Respiratory Therapy</li> <li>O Private Duty Nursing</li> <li>O Day Care Program</li> <li>O Home Delivered Meals Program</li> <li>O All Others (specify)</li> <li>S Telemedicine</li> <li>O Total (sum of lines 1-19) (2)</li> <li>O Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.</li> </ol>	62, 641 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		9, 643 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ \end{array}$

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE CO	STS TO HHA COST CEN	ITERS	Provider CO	CN: 15-0030 15-7430	Period: From 01/01/2020 To 12/31/2020 Home Health		pared:
					Agency I		
Cost Center Descript	on CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
	14.00	15.00	16.00	24.00	25.00	26.00	
<ol> <li>Administrative and General</li> <li>Administrative and General</li> <li>Skilled Nursing Care</li> <li>Whysical Therapy</li> <li>Occupational Therapy</li> <li>Speech Pathology</li> <li>Medical Social Services</li> <li>Home Health Aide</li> <li>Supplies (see instructions)</li> <li>Drugs</li> <li>O DHE</li> <li>O BME</li> <li>Mem Ealth Promotion Activitie</li> <li>O Private Duty Nursing</li> <li>O Home Delivered Meals Program</li> <li>O Home Althers (specify)</li> <li>Supplies (see instructions)</li> <li>O DHE</li> <li>O DHE</li> <li>O Health Promotion Activitie</li> <li>O Day Care Program</li> <li>O Home Delivered Meals Program</li> <li>O Home Althers (specify)</li> <li>Supplies (see instructions)</li> <li>O Total (sum of lines 1-19)</li> <li>O Unit Cost Multiplier: colu</li> <li>Line 1 divided by the of column 26, line 1, rounded</li> <li>decimal places.</li> </ol>	s 0 s 0 s 0 s 0 am 0 (2) 3,602 mn sum s		7, 267 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	573, 9 140, 3 10, 4 42, 9	342     0       998     0       372     0       155     0       0     0       006     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0	532, 598 891, 842 573, 998 140, 372 10, 455 0 42, 906 0 42, 906 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50
Cost Center Descript	A&G (see Part	Total HHA Costs		1			_
1.00 Administrative and General	27.00	28.00					1.00
<ul> <li>3.00 Physical Therapy</li> <li>4.00 Occupational Therapy</li> <li>5.00 Speech Pathology</li> <li>6.00 Medical Social Services</li> <li>7.00 Home Health Aide</li> <li>8.00 Supplies (see instructions</li> <li>9.00 Drugs</li> <li>10.00 DME</li> <li>11.00 Home Dialysis Aide Service</li> <li>12.00 Respiratory Therapy</li> <li>13.00 Private Duty Nursing</li> <li>14.00 Clinic</li> <li>15.00 Health Promotion Activitie</li> <li>16.00 Day Care Program</li> <li>17.00 Home Delivered Meals Progr</li> <li>18.00 Homemaker Service</li> <li>19.00 All Others (specify)</li> <li>19.50 Telemedicine</li> <li>20.00 Total (sum of lines 1-19)</li> <li>21.00 Unit Cost Multiplier: colu</li> <li>26, line 1 divided by the of column 26, line 20 minu</li> </ul>	s 0 s 0 s 0 am 0 (2) 532,598 mn 0.320925 sum	758, 208 185, 421 13, 810 0 56, 676 0 0 0 0 0 0 0 0 0 0 0 0 0					$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 3.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 14.00\\ 15.00\\ 19.00\\ 19.00\\ 19.00\\ 20.00\\ 21.00\\ \end{array}$

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems		NRY COUNTY MEM				u of Form CMS-2	
ALLOCATION OF GENERAL SERVICE COSTS T BASIS	O HHA COST CEN	TERS STATISTIC	AL Provider CO	CN: 15-0030 15-7430	Period: From 01/01/2020 To 12/31/2020	Worksheet H-2 Part II Date/Time Pre 7/30/2021 9:1	pared:
					Home Health Agency I	PPS	
	CAPI TAL REL	ATED COSTS			Agency I		
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	n	o ADMI NI STRATI V E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
1.00 Administrative and General	1.00	2.00	<u>4.00</u> 1,153,854	5A	5.00 0 375,563	7.00	1.00
<ul> <li>2.00 Skilled Nursing Care</li> <li>3.00 Physical Therapy</li> <li>4.00 Occupational Therapy</li> <li>5.00 Speech Pathology</li> <li>6.00 Medical Social Services</li> <li>7.00 Home Health Aide</li> <li>8.00 Supplies (see instructions)</li> <li>9.00 Drugs</li> <li>10.00 DME</li> <li>11.00 Home Dialysis Aide Services</li> <li>12.00 Respiratory Therapy</li> <li>13.00 Private Duty Nursing</li> <li>14.00 Clinic</li> <li>15.00 Health Promotion Activities</li> <li>16.00 Day Care Program</li> <li>17.00 Home Delivered Meals Program</li> <li>18.00 All Others (specify)</li> <li>19.50 Telemedicine</li> </ul>					$ \begin{smallmatrix} 0 & 745, 236 \\ 0 & 479, 641 \\ 0 & 117, 297 \\ 0 & 8, 736 \\ 0 & 0 \\ 0 & 35, 853 \\ 0 & 0 \\ 0$		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ \end{array}$
20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated	0 0	0 0	1, 153, 854 375, 563		1, 762, 326 346, 692		
22.00 Unit cost multiplier Cost Center Description	0.000000 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	0.000000 HOUSEKEEPI NG (HOURS OF SERVI CE)	O. 325486 DI ETARY (PATI ENT DAYS)	CAFETERI A (FTE' S)	0. 196724 NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	27. 354148 CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	22.00
	8.00	9.00	10.00	11.00	13.00	14.00	1.00
<ol> <li>Administrative and General</li> <li>OO Skilled Nursing Care</li> <li>OO OPhysical Therapy</li> <li>OO Occupational Therapy</li> <li>OO Speech Pathology</li> <li>OO Medical Social Services</li> <li>OO Home Health Aide</li> <li>OO Drugs</li> <li>OO DME</li> <li>OO Memodel and Services</li> <li>OO DME</li> <li>OO Home Dialysis Aide Services</li> <li>OO Respiratory Therapy</li> <li>OO Health Promotion Activities</li> <li>OO Day Care Program</li> <li>OO Home Delivered Meals Program</li> <li>OO Home Service</li> <li>OO Total (sum of lines 1-19)</li> <li>OO Total cost to be allocated</li> <li>OO Total up in the promotion activities</li> </ol>	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	40 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0     0       0     0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$

Heal th	Financial Systems	HE	NRY COUNTY MEMOR	I AL HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATI STI CAL	Provider CCN:	15-0030	Peri od:	Worksheet H-2	
BASI S				HHA CCN:	15-7430	From 01/01/2020 To 12/31/2020	Part II Date/Time Pre	narod
				TITIA CON.	15-7430	10 12/31/2020	7/30/2021 9:1	
						Home Health	PPS	
						Agency I		
	Cost Center Description	PHARMACY	MEDI CAL					
		(COSTED	RECORDS &					
		REQUIS.)	LIBRARY					
			(TIME SPENT)					
		15.00	16.00			-		
1.00	Administrative and General	13.00	10.00					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	o					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
	Clinic	0	0					14.00
	Health Promotion Activities	0	0					15.00
	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00 19.00
	All Others (specify) Telemedicine	0	0					19.00
	Total (sum of lines 1-19)	0	12					20.00
	Total cost to be allocated	0	7, 267					20.00
	Unit cost multiplier	0. 000000	605. 583333					21.00
22.00		0.000000	000.000000					22.00

	Financial Systems		NRY COUNTY MEMO				u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-0030	Period: From 01/01/2020	Worksheet H-3 Part I	
				HHA CCN:	15-7430	To 12/31/2020		pared: 5 am
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
			Part I)	Part II)			col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, A	GGREGATE OF T	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	
	COST LIMITATION							
	Cost Per Visit Computation							
. 00	Skilled Nursing Care	2.00		_	1, 178, 0		219.54	1.0
. 00	Physical Therapy	3.00		0			165.44	2.0
. 00	Occupational Therapy	4.00		0			454.46	3.0
. 00	Speech Pathology	5.00		0	13, 8		109. 60	4.0
. 00	Medical Social Services	6.00	1 1			0 0	0.00	5.00
. 00	Home Health Aide	7.00			56, 6		38. 24	6.0
. 00	Total (sum of lines 1-6)		2, 192, 171	0				7.0
					Program Visi	ts		
					-			
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					to	Deducti bl es		
					Deducti bl es			
			1.00	2.00	Coi nsurance		F 00	
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	5.00	
8. 00	Limitation Cost Computation Skilled Nursing Care	1	17140	0	1	9		8.00
. 00 . 01	Skilled Nursing Care		26900	0		6		8. 0 <sup>′</sup>
. 01	Skilled Nursing Care		34620	0		34		8.02
. 02	Skilled Nursing Care		99915	0				8.0
. 00	Physical Therapy		17140	0		18		9.0
. 00	Physical Therapy		26900	0		13		9.0
9. 02	Physical Therapy		34620	0		62		9.0
02	Physical Therapy		99915	0				9.0
0.00	Occupational Therapy		17140	0		0		10.0
0.01	Occupational Therapy		26900	0		0		10.0
0.02	Occupational Therapy		34620	0		0		10.0
0.03	Occupational Therapy		99915	0		29		10.0
1.00	Speech Pathology		17140	0		0		11.0
1.01	Speech Pathology		26900	Ő		0		11.0
1.02	Speech Pathology		34620	Ő		0		11.0
1.03	Speech Pathology		99915	Ő		70		11.0
2.00	Medical Social Services		17140	Ő		0		12.0
2.01	Medical Social Services		26900	Ő		0		12.0
2.02	Medical Social Services		34620	0		0		12.0
2.02	Medical Social Services		99915	0		0		12.0
	Home Heal th Ai de		17140	0		0		13.0
3.00	Home Heal th Ai de		26900	0		0		13.0
3.01	Home Heal th Aide		34620	0		0		13.0
3.02	Home Heal th Aide		99915	0		47		13.0
4.00				0				14.0
50	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges	Ratio (col 3	1 1. 0
	cost center bescription	H-2 Part I,	Costs (from	Ancillary	Costs (col s.		÷ col. 4)	
		col. 28, line		Costs (from	1 + 2)	Records)		
		20, 1110		•				
			Part I)	Part II)				
		0	Part I) 1.00	<u>Part II)</u> 2.00	3.00	4,00	5.00	
	Supplies and Drugs Cost Comput		Part I) 1.00	2.00	3.00	4.00	5.00	
5. 00	Supplies and Drugs Cost Comput Cost of Medical Supplies		1.00			4.00	5.00 0.000000	15.0

PORTIO	inancial Systems NMENT OF PATIENT SERVICE COSTS			Provider C	N· 15-0030	Peri od:	u of Form CMS-2 Worksheet H-3	
		5		HHA CCN:	15-7430	From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	parec
				Title	XVIII	Home Health	7/30/2021 9:1 PPS	5 am
			Program Visits		Cost of	Agency I		
					Servi ces			
	Cost Center Description	Part A	Part Not Subject	Subject to	Part A	Part B Not Subject	Subject to	
	cost center bescription	Part A		Deductibles &	Part A	to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
<b>D 1</b>		6.00	7.00	8.00	9.00	10.00	11.00	
	ART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM L	IMITATION COST, C	OR BENEFICIARY	
	ost Per Visit Computation							1
	killed Nursing Care	C	1, 578			0 346, 434		1.
00 Ph	hysical Therapy	C	1, 949			0 322, 443		2.
00 00	ccupational Therapy	C	021			0 149, 517		3.
	peech Pathology	C	70			0 7,672		4.
	edical Social Services	0	0			0 0		5.
	ome Health Aide	0	• • •			0 20, 917 0 846, 983		6. 7.
<u> </u>	otal (sum of lines 1-6) Cost Center Description	U	4,473			0 040, 903		/.
		6.00	7.00	8.00	9.00	10.00	11.00	
	mitation Cost Computation							
	killed Nursing Care							8.
	killed Nursing Care							8.
	killed Nursing Care killed Nursing Care							8.
	hysical Therapy							9.
	hysical Therapy							9.
	hysical Therapy							9.
	hysical Therapy							9.
	ccupational Therapy							10.
	ccupational Therapy							10.
	ccupational Therapy							10.
	ccupational Therapy peech Pathology							10.
	peech Pathology							111.
	peech Pathology							111.
	peech Pathology							11.
00 Me	edical Social Services							12.
	edical Social Services							12.
	edical Social Services edical Social Services							12.
	ome Health Aide							12.
	ome Health Aide							13.
	ome Heal th Aide							13.
	ome Health Aide							13.
00 To	otal (sum of lines 8-13)							14.
		Prog	ram Covered Cha	rges	Cost of			
					Servi ces			
			Part	В		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
				Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
		(	Coi nsurance	0.00	0.00	Coi nsurance	11.00	
C.,	upplies and Drugs Cost Computa	6.00	7.00	8.00	9.00	10.00	11.00	
	ost of Medical Supplies	C	1, 196	0		0 0	0	15.
	ost of Drugs		0	0		0		16.

	Financial Systems		NRY COUNTY MEMO			u of Form CMS-2	
APPORT	IONMENT OF PATIENT SERVICE COST	ГS		Provider CCN: 15-0030	Peri od:	Worksheet H-3	
				HHA CCN: 15-7430	From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	pared:
						7/30/2021 9:1	5 am
				Title XVIII	Home Health Agency I	PPS	
	Cost Center Description	Total Program			/ //geney /		
		Cost (sum of					
		cols. 9-10)					
		12.00					
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE F	ROGRAM COST, A	GGREGATE OF THE PROGRAM L	IMITATION COST, O	R BENEFICIARY	
	Cost Per Visit Computation						1
1.00	Skilled Nursing Care	346, 434					1.0
2.00	Physi cal Therapy	322, 443					2.0
3.00	Occupational Therapy	149, 517					3.0
4.00	Speech Pathology	7, 672					4.0
5.00	Medical Social Services	0					5.0
6.00	Home Health Aide	20, 917					6.0
7.00	Total (sum of lines 1-6)	846, 983					7.0
	Cost Center Description	12.00			-		-
	Limitation Cost Computation	12.00					
8.00	Skilled Nursing Care						1 8.0
B. 01	Skilled Nursing Care						8.0
3. 02	Skilled Nursing Care						8.0
3.03	Skilled Nursing Care						8.0
9.00	Physical Therapy						9.0
9.01	Physical Therapy						9.0
9.02	Physical Therapy						9.0
9. 03	Physical Therapy						9.0
0.00	Occupational Therapy						10.0
0. 01	Occupational Therapy						10.0
0. 02	Occupational Therapy						10.0
0.03	Occupational Therapy						10.0
1.00	Speech Pathology						11.0
11.01	Speech Pathology						11.0
11.02	Speech Pathology						11.0
11.03	Speech Pathology						11.0
2.00	Medical Social Services						12.0
2.01	Medical Social Services						12.0
2.02	Medical Social Services Medical Social Services						12.0
12.03	Home Health Aide						12.0
13.00	Home Health Aide						13.0
13.01	Home Health Aide						13.0
13.02	Home Heal th Aide						13.0

Heal th	Financial Systems	HE	NRY COUNTY MEM	IORI AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-0030	Period: From 01/01/2020	Worksheet H-3 Part II	
				HHA CCN:	15-7430	To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
				Title	× XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
		9, line	-	provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNI SHED	BY SHARED HOSP	ITAL DEPARTME	INTS		
1.00	Physical Therapy	66.00	1.009971	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 577770	0		Ocol. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 674580	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 170158	0		0 col. 2, line 1	5.00	4.00
5.00	Cost of Drugs	73.00	0. 429626	0		0 col. 2, line 1	6.00	5.00
					•			•

	Financial Systems HENRY COUNTY MEMOI ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider C		Perio	od:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	15-7430		01/01/2020 12/31/2020		
		Title	XVIII		ne Health gency I	PPS	<u>o u</u>
					Par	t B	
			Part A		t Subject to uctibles &	Subject to Deductibles & Coinsurance	
			1.00	Со	i nsurance	2.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUS	TOMARY CHARGE	1.00		2.00	3.00	
	Reasonable Cost of Part A & Part B Services						1
00	Reasonable cost of services (see instructions)			0	0	0	1 1
00	Total charges			0	0	0	2
	Customary Charges						
00	Amount actually collected from patients liable for payment f on a charge basis (from your records)	for services		0	0	0	3
00	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in with 42 CFR §413.13(b)			0	0	0	4
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	000	0. 000000	0.000000	5
00	Total customary charges (see instructions)		0.0000	0	0.000000	0.000000	
00	Excess of total customary charges over total reasonable cost only if line 6 exceeds line 1)	t (complete		0	0	0	7
00	Excess of reasonable cost over customary charges (complete of 1 exceeds line 6)	onlyifline		0	0	0	8
00	Primary payer amounts			0	0	0	9
					Part A	Part B	
					Services 1.00	Services 2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT						
. 00	Total reasonable cost (see instructions)				0		10
. 00	Total PPS Reimbursement - Full Episodes without Outliers				0	614, 897	
. 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes				0	55, 560 5, 959	
. 00	Total PPS Reimbursement - PEP Episodes				0	2, 293	
. 00	Total PPS Outlier Reimbursement - Full Episodes with Outlier	~~			0	2, 2, 3	
. 00	Total PPS Outlier Reimbursement - PEP Episodes	5			0	20,071	
. 00	Total Other Payments				0	0	
. 00	DME Payments				0	0	
. 00	Oxygen Payments				0	0	
. 00	Prosthetic and Orthotic Payments				0	0	
. 00	Part B deductibles billed to Medicare patients (exclude coir	nsurance)				0	21
. 00	Subtotal (sum of lines 10 thru 20 minus line 21)				0	699, 400	22
. 00	Excess reasonable cost (from line 8)				0	0	23
. 00	Subtotal (line 22 minus line 23)				0	699, 400	24
. 00	Coinsurance billed to program patients (from your records)					0	25
	Net cost (line 24 minus line 25)				0	699, 400	26
	Reimbursable bad debts (from your records)						27
. 00	Reimbursable bad debts for dual eligible beneficiaries (see		1				28
. 00	Total costs - current cost reporting period (line 26 plus li	ne 27)			0	699, 400	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	>			0	0	
. 50	Pioneer ACO demonstration payment adjustment (see instruction				0	0	
. 99	Demonstration payment adjustment amount before sequestration	1			0	600,400	
. 00	Subtotal (see instructions)				0	699, 400	
. 01	Sequestration adjustment (see instructions)				0	5,044	
. 02	Demonstration payment adjustment amount after sequestration				0	0 694, 356	
. 00 . 00	Interim payments (see instructions) Tentative settlement (for contractor use only)				0	094, 350 0	
	Balance due provider/program (line 31 minus lines 31.01, 32,	and 33)			0	0	
1 00		unu 33/		1	U	0	1 34
. 00	Protested amounts (nonallowable cost report items) in accord		S Pub. 15-2		0	0	35

	SIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider C	CN: 15-0030		eriod:	Worksheet H-5	
PR	DGRAM BENEFI CLARI ES	HHA CCN:	15-7430		rom 01/01/2020 o 12/31/2020	Date/Time Prep 7/30/2021 9:15	
					Home Health Agency I	PPS	<u> </u>
		I npati en	it Part A	1		тв	
		mm/dd/yyyy 1.00	Amount 2.00		mm/dd/yyyy 3.00	Amount 4.00	
00	Total interim payments paid to provider	1.00	2.00	0		4.00	1
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,			0		0	2
0	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3
	Program to Provider		1				
)1				0		0	З
)2 )3				0 0		0	3
)4				0		0	3
)5				0		0	3
~	Provider to Program						
0 1				0 0		0	
2				0		0	
3				0		0	3
4				0		0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		694, 356	Z
	TO BE COMPLETED BY CONTRACTOR		1		I		
0	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						í
	Program to Provider		-				
)1				0		0	5
)2 )3				0 0		0	E
5	Provider to Program			0			
0				0		0	5
1				0 0		0	5
2	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		0	5
0	5.50-5.98) Determined net settlement amount (balance due) based on						6
1	the cost report. (1) SETTLEMENT TO PROVIDER			0		о	2
)1 )2	SETTLEMENT TO PROVIDER			0		0	6
0	Total Medicare program liability (see instructions)			0		694, 356	7
					Contractor Number	NPR Date (Mo/Day/Yr)	
		(	C		1.00	2.00	

ALYSI S	S OF HOSPITAL-BASED HOSPICE COSTS		Provider C		eriod:	Worksheet O	
			Hospi ce CC		rom 01/01/2020 o 12/31/2020	Date/Time Pre 7/30/2021 9:1	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col. 1 pl us	RECLASSI FI - CATI ONS	SUBTOTAL	
		1.00	2.00	col. 2) 3.00	4.00	5.00	
GE	ENERAL SERVICE COST CENTERS	- · · ·					
00 C/	AP REL COSTS-BLDG & FIXT*		0	C	0	0	1
00 C/	AP REL COSTS-MVBLE EQUIP*		0	C	0 0	0	2
	MPLOYEE BENEFITS DEPARTMENT*	0	6, 026	6, 026		0	3
	DMINISTRATIVE & GENERAL*	80, 139	374, 019			454, 158	
	LANT OPERATION & MAINTENANCE*	0	72, 191	72, 191		72, 191	5
	AUNDRY & LINEN SERVICE*	0	0	0		0	
	OUSEKEEPI NG*	0	0	0		0	
		0	0	0		0	
	URSING ADMINISTRATION*	0	0		-	0	
	OUTINE MEDICAL SUPPLIES*	0	346	346		346 0	
	EDI CAL RECORDS* TAFF TRANSPORTATI ON*	0	0		0	0	1
	OLUNTEER SERVICE COORDINATION*	0	0		0	0	
	HARMACY*	0	0		0	0	
	HYSICIAN ADMINISTRATIVE SERVICES*	0	0			0	
	THER GENERAL SERVICE*	0	0			0	
1	ATI ENT/RESI DENTI AL CARE SERVI CES	0	0			0	17
	IRECT PATIENT CARE SERVICE COST CENTERS			<u> </u>	II		1 ''
	NPATIENT CARE-CONTRACTED**		0	(	0	0	25
	HYSI CI AN SERVI CES**	27, 375	0	27, 375	o o	27, 375	
	URSE PRACTI TI ONER**	0	0	C	0	0	
	EGI STERED NURSE**	338, 747	0	338, 747	0	338, 747	
00 LI	PN/LVN**	0	0	C	0 0	0	29
00 PI	HYSI CAL THERAPY**	0	0	( C	0 0	0	30
. 00   00	CCUPATIONAL THERAPY**	0	0	C	0	0	31
. 00   SI	PEECH/LANGUAGE PATHOLOGY**	0	0	C	0	0	
	EDI CAL SOCI AL SERVI CES**	36, 957	0	36, 957	0	36, 957	33
	PIRITUAL COUNSELING**	0	0	C	0 0	0	
	I ETARY COUNSELI NG**	0	0	C	0 0	0	
	OUNSELING - OTHER**	0	0	C	0 0	0	
1	OSPICE AIDE & HOMEMAKER SERVICES**	30, 308	0	30, 308		30, 308	
	URABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	C	0	0	
	ATIENT TRANSPORTATION**	0	0	0	0	0	
	MAGING SERVICES**	0	0		0	0	
	ABS & DI AGNOSTI CS**	0	0		0	0	
	EDI CAL SUPPLI ES-NON-ROUTI NE**	0	0		0	0	
	RUGS CHARGED TO PATIENTS** UTPATIENT SERVICES**	0	0			0	
	ALLIATIVE RADIATION THERAPY**	0	0			0	
	ALLIATIVE RADIATION THERAPY**	0	0			0	
	THER PATIENT CARE SERVICES (SPECIFY)**	0	0		0	0	
	ONREIMBURSABLE COST CENTERS	<u>Ч</u>	0		·V	0	1
	EREAVEMENT PROGRAM *	0	0	C	0	0	60
	OLUNTEER PROGRAM *	0	0		-	0	
	UNDRAI SI NG*	0	0		0	0	
	OSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		0	0	
	ALLIATIVE CARE PROGRAM*	0	0	0	0	0	
	THER PHYSICIAN SERVICES*	0	0	0	0	0	
	ESIDENTIAL CARE*	0	0	C	0	0	
	DVERTI SI NG*	0	0	C	0	0	
	ELEHEALTH/TELEMONI TORI NG*	0	0	C	0	0	
	HRI FT STORE*	0	0	C	0	0	
	URSING FACILITY ROOM & BOARD*	0	0	C	0	0	
00 0	THER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	
0. OO T(	INTAI	513, 526	452, 582	966, 108	-6, 026	960, 082	1100

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

IALYSI S	OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN	: 15-0030	Peri od:	Worksheet (	0
			Hospi ce CCN:	15-1564	From 01/01/2020 To 12/31/2020	Date/Time   7/30/2021	
					Hospi ce I	11 307 2021	<u>7. 15 u</u>
		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)				
		6.00	7.00				
	NERAL SERVICE COST CENTERS		-				
	AP REL COSTS-BLDG & FIXT*	0	0				1
	AP REL COSTS-MVBLE EQUIP*	0	0				2
	MPLOYEE BENEFITS DEPARTMENT*	0	0				3
	DMENISTRATIVE & GENERAL* _ANT OPERATION & MAINTENANCE*	-15, 674	438, 484				4
	AUNDRY & LINEN SERVICE*	0	72, 191 0				5
-	DUSEKEEPING*	0	0				
-	ETARY*	0	0				8
	JRSI NG ADMI NI STRATI ON*	0	0				
1	DUTINE MEDICAL SUPPLIES*	0	346				10
1	EDI CAL RECORDS*	0	0				11
1	TAFF TRANSPORTATION*	0	o				12
	DLUNTEER SERVICE COORDINATION*	0	o				1:
	HARMACY*	0	o				14
	HYSI CI AN ADMI NI STRATI VE SERVI CES*	0	o				15
	THER GENERAL SERVICE*	0	o				16
	ATIENT/RESIDENTIAL CARE SERVICES						1
DI	RECT PATIENT CARE SERVICE COST CENTERS						
00 11	VPATIENT CARE-CONTRACTED**	0	0				25
00 PH	HYSI CI AN SERVI CES**	0	27, 375				20
00 NL	JRSE PRACTI TI ONER**	0	0				27
00 RE	EGISTERED NURSE**	0	338, 747				28
00 LF	PN/LVN**	0	0				29
00 PH	HYSI CAL THERAPY**	0	0				30
	CCUPATIONAL THERAPY**	0	0				3
	PEECH/LANGUAGE PATHOLOGY**	0	0				32
	EDI CAL SOCI AL SERVI CES**	0	36, 957				33
1	PIRITUAL COUNSELING**	0	0				34
	ETARY COUNSELING**	0	0				35
	DUNSELING – OTHER** DSPICE AIDE & HOMEMAKER SERVICES**	0	20, 209				36
	JRABLE MEDICAL EQUIPMENT/OXYGEN**	0	30, 308 0				38
	ATIENT TRANSPORTATION**	0	0				30
	AGING SERVICES**	0	0				4(
	ABS & DI AGNOSTI CS**	0	0				4
	EDI CAL SUPPLI ES-NON-ROUTI NE**	0	o				42
	RUGS CHARGED TO PATIENTS**	0	o				42
	JTPATIENT SERVICES**	0	o				43
	ALLIATIVE RADIATION THERAPY**	0	o				44
	ALLIATIVE CHEMOTHERAPY**	0	o				45
T0 00	THER PATIENT CARE SERVICES (SPECIFY)**	0	O				46
NO	NREIMBURSABLE COST CENTERS						
00 BE	EREAVEMENT PROGRAM *	0	0				60
	DLUNTEER PROGRAM *	0	0				6
	JNDRAI SI NG*	0	0				62
	DSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63
	ALLIATIVE CARE PROGRAM*	0	0				64
	THER PHYSICIAN SERVICES*	0	0				6
	ESI DENTI AL CARE*	0	0				66
	OVERTI SI NG*	0	0				6
	ELEHEALTH/TELEMONI TORI NG*	0	0				68
1	IRI FT STORE*	0	0				69
	JRSING FACILITY ROOM & BOARD*	0	0				70
	THER NONREIMBURSABLE (SPECIFY)*	0	0				71
). OO TC	JIAL	-15, 674	944, 408				100

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

Health Financial Systems	HENRY COUNTY MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FO	OR HOSPICE ROUTINE HOME	Provider C		Period:	Worksheet 0-2	
CARE				rom 01/01/2020		
		Hospi ce CC	N: 15-1564   T	o 12/31/2020	Date/Time Pre 7/30/2021 9:1	
				Hospi ce I	17 007 2021 7.1	
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CEN	TERS					
25.00 INPATIENT CARE-CONTRACTED						25.00
26.00 PHYSICIAN SERVICES	27, 105	0	27, 105	0	27, 105	26.00
27.00 NURSE PRACTITIONER	0	0	0	0 0	0	27.00
28.00 REGI STERED NURSE	335, 411	0	335, 411	0	335, 411	28.00
29.00 LPN/LVN	0	0	c	0 0	0	29.00
30. 00 PHYSI CAL THERAPY	0	0	0	0 0	0	30.00
		0			0	21 00

31.0	U UCCUPATIONAL THERAPY	0	0	0	0	01	31.00
32.0	0 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.0	0 MEDICAL SOCIAL SERVICES	36, 593	0	36, 593	0	36, 593	33.00
34.0	O SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.0	D DI ETARY COUNSELING	0	0	0	0	0	35.00
36.0	0 COUNSELING - OTHER	0	0	0	0	0	36.00
37.0	0 HOSPICE AIDE & HOMEMAKER SERVICES	30, 010	0	30, 010	0	30, 010	37.00
38.0	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.0	0 PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.0	D IMAGING SERVICES	0	0	0	0	0	40.00
41.0	D LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.0	0 MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.5	D DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.0	0 OUTPATI ENT SERVI CES	0	0	0	0	0	43.00
44.0	0 PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.0	0 PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.0	0 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00 TOTAL *		429, 119	0	429, 119	0	429, 119	100.00
* Transfer the amount in column 7 to Wkst. 0-5. column 1. line 51.							

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

		ADJUSTMENTS	TOTAL (col. 5					
			± col. 6)					
		6.00	7.00					
DIRECT PATIENT CARE SERVICE COST CENTERS								
	NPATIENT CARE-CONTRACTED				25.00			
	HYSI CI AN SERVI CES	0	27, 105		26.00			
27.00 NI	URSE PRACTITIONER	0	0		27.00			
28.00 RE	EGI STERED NURSE	0	335, 411		28.00			
29.00 LF	PN/LVN	0	0		29.00			
	HYSI CAL THERAPY	0	0		30.00			
	CCUPATI ONAL THERAPY	0	0		31.00			
	PEECH/LANGUAGE PATHOLOGY	0	0		32.00			
	EDI CAL SOCI AL SERVI CES	0	36, 593		33.00			
	PIRITUAL COUNSELING	0	0		34.00			
	I ETARY COUNSELI NG	0	0		35.00			
	OUNSELING - OTHER	0	0		36.00			
	OSPICE AIDE & HOMEMAKER SERVICES	0	30, 010		37.00			
	URABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00			
	ATI ENT TRANSPORTATI ON	0	0		39.00			
	MAGI NG SERVI CES	0	0		40.00			
	ABS & DI AGNOSTI CS	0	0		41.00			
	EDI CAL SUPPLI ES-NON-ROUTI NE	0	0		42.00			
	RUGS CHARGED TO PATIENTS	0	0		42.50			
	UTPATI ENT SERVI CES	0	0		43.00			
	ALLIATIVE RADIATION THERAPY	0	0		44.00			
	ALLIATIVE CHEMOTHERAPY	0	0		45.00			
	THER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00			
100.00 T(	OTAL *	0	429, 119	9	100.00			
* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.								

		NRY COUNTY MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E INPATIENT	Provider CC	N: 15-0030	Period:	Worksheet 0-3	}
RESPI T	e care		Hospi ce CCN	: 15-1564	From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	epared: 5 am
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATIONS		
				<u>col. 2)</u>			
	DUDENT DATIENT AADE OFDIVAE AAAT OFNITEDO	1.00	2.00	3.00	4.00	5.00	
05 00	DI RECT PATI ENT CARE SERVICE COST CENTERS				0		1 05 00
25.00	INPATIENT CARE-CONTRACTED	144	0	1	0 0	0	
26.00	PHYSICIAN SERVICES NURSE PRACTITIONER	144	0	1.	44 0	144	
27.00		1 770	0	1 7	0 0	0	
28.00 29.00	REGI STERED NURSE	1, 779	0	1, 7	/9 0	1, 779 0	1
	PHYSI CAL THERAPY	0	0		0 0	0	
30.00	OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0			0	32.00
33.00	MEDICAL SOCIAL SERVICES	194	0	10	94 0	194	
	SPIRITUAL COUNSELING	0	0	1		0	
	DI ETARY COUNSELING	0	0		0 0	0	1
36.00	COUNSELING - OTHER	0	0		0 0	0	
	HOSPICE ALDE & HOMEMAKER SERVICES	159	0	1!	59 0	159	
	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	
39.00	PATI ENT TRANSPORTATI ON	0	0		0 0	0	39.00
40.00	I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0		0 0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0		0 0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	О		0 0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	
100.00	TOTAL *	2, 276	0	2, 2	76 0	2, 276	100.00

 44.00
 PALLIATIVE KADIATION THERAPY
 0

 45.00
 PALLIATIVE CHEMOTHERAPY
 0

 46.00
 OTHER PATIENT CARE SERVICES (SPECIFY)
 0

 100.00
 TOTAL \*
 2,276

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	144	26.00
27.00	NURSE PRACTI TI ONER	0	0	27.00
28.00	REGI STERED NURSE	0	1, 779	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	194	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	159	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
	PALLIATIVE CHEMOTHERAPY	0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
	TOTAL *	0	2, 276	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 52		

Heal th	Financial Systems He	ENRY COUNTY MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	CE GENERAL	Provider CC	CN: 15-0030	Peri od:	Worksheet 0-4	
I NPATI	ENT CARE		Hospi ce CCN	I: 15-1564	From 01/01/2020 To 12/31/2020		
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATIONS		
				col . 2)			
	DUDENT DATIENT CADE CEDULAE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
25 00	DI RECT PATI ENT CARE SERVICE COST CENTERS		0		0 0	0	
25.00	INPATIENT CARE-CONTRACTED	10/	0	1	0 0	0	
26.00 27.00	PHYSI CI AN SERVI CES NURSE PRACTI TI ONER	126	0	I	26 0	126	26.00
	REGISTERED NURSE	1, 557	0	1, 5	57 0	0 1, 557	27.00
	LPN/LVN	1, 557	0	1, 5	5/ 0	1, 557	28.00
	PHYSICAL THERAPY	0	0		0 0	0	30.00
	OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
	SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	
	MEDICAL SOCIAL SERVICES	170	0	1	70 0	170	
	SPIRITUAL COUNSELING	0	0	I		0	•
	DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00	COUNSELING - OTHER	0	0		0 0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	139	0	1	39 0	139	37.00
	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	o		0 0	0	38.00
	PATIENT TRANSPORTATION	0	0		0 0	0	39.00
40.00	I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0		0 0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0		0 0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100.00	TOTAL *	1, 992	0	1, 9	92 0	1, 992	100.00

100.00 TOTAL \* 1, 992 \* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	126	26.00
27.00	NURSE PRACTI TI ONER	0	0	27.00
28.00	REGI STERED NURSE	0	1, 557	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	170	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	139	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
	PALLIATIVE CHEMOTHERAPY	0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
	TOTAL *	0	1, 992	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 53		

Heal th	Financial Systems HENRY COUNTY MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0030	Peri od:	Worksheet 0-5	
EXPENS	SES FOR ALLOCATION			From 01/01/2020		
		Hospi ce CC	N: 15-1564	To 12/31/2020		
				lloopi oo l	7/30/2021 9:1	5 am _
	Descriptions		HOSPI CE	Hospi ce I GENERAL	TOTAL	
	Descriptions		DI RECT	SERVI CE	EXPENSES (sum	
				e EXPENSES FROM	of cols. 1 +	
				) WKST B PART I	2)	
				(see	2)	
				instructions)		
			1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS		1			
1.00	CAP REL COSTS-BLDG & FIXT			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 167, 145	167, 145	3.00
4.00	ADMI NI STRATI VE & GENERAL		438, 48		657, 153	4.00
5.00	PLANT OPERATION & MAINTENANCE		72, 19	62, 613	134, 804	5.00
6.00	LAUNDRY & LINEN SERVICE			0 0	0	6.00
7.00	HOUSEKEEPING			0 0	0	7.00
8.00	DIETARY			0 0	0	8.00
9.00	NURSING ADMINISTRATION			0 0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES		34	16 2, 057	2, 403	10.00
11.00	MEDI CAL RECORDS			0 4, 239	4, 239	11.00
12.00	STAFF TRANSPORTATION			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00	PHARMACY			0 0	0	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES			0	0	15.00
16.00	OTHER GENERAL SERVICE			0 0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES			0	0	17.00
	LEVEL OF CARE		1			
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		429, 1		429, 119	
52.00	HOSPI CE I NPATI ENT RESPI TE CARE		2, 2		2, 276	52.00
53.00	HOSPICE GENERAL INPATIENT CARE		1, 9	92	1, 992	53.00
	NONREI MBURSABLE COST CENTERS		1			1 1 0 0 0
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	61.00
62.00	FUNDRAI SI NG			0	0	62.00
63.00	HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	65.00
66.00	RESIDENTIAL CARE			0	0	66.00
67.00	ADVERTI SI NG			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	68.00
69.00	THRIFT STORE			0	0	69.00
	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)			0	0	71.00
99.00	NEGATI VE COST CENTER		044.4	0	0	99.00
100.00	)  TOTAL		944, 40	08 454, 723	1, 399, 131	100.00

Heal th	Financial Systems HI	ENRY COUNTY MEMO	ORIAL HOSPITAL			In Lieu	u of Form CMS-2	2552-10
COST /	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI	ERVICE COSTS	Provider C Hospice CC			iod: m 01/01/2020 12/31/2020	Worksheet 0-6 Part I Date/Time Pre 7/30/2021 9:1	pared:
						Hospi ce I		
	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBL EQUI P	LE	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00		3.00	3A	
	GENERAL SERVICE COST CENTERS	I				I	-	
1.00	CAP REL COSTS-BLDG & FIXT	0	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	167, 145	0		0	167, 145		3.00
4.00	ADMI NI STRATI VE & GENERAL	657, 153	0	1	0	0	657, 153	4.00
5.00	PLANT OPERATION & MAINTENANCE	134, 804	0	1	0	0	134, 804	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0	0	0	6.00
7.00	HOUSEKEEPING	0	0		0	0	0	7.00
8.00	DI ETARY	0	0		0	0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0		0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	2, 403	0		0	0	2, 403	10.00
11.00	MEDI CAL RECORDS	4, 239	0		0	0	4, 239	11.00
12.00	STAFF TRANSPORTATION	0	0		0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0	0	0	13.00
14.00	PHARMACY	0	0		0	0	0	14.00
15.00	PHYSI CLAN ADMI NI STRATI VE SERVI CES	0	0		0	0	0	15.00
16.00		0	0		0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0		0		0	17.00
	LEVEL OF CARE	· · · ·			_			
50.00	HOSPICE CONTINUOUS HOME CARE	0				0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	429, 119				165, 499	594, 618	
52.00	HOSPICE INPATIENT RESPITE CARE	2, 276	0		0	878	3, 154	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1, 992	0		0	768	2, 760	53.00
	NONREI MBURSABLE COST CENTERS			1	-	-		
60.00	BEREAVEMENT PROGRAM	0	0		0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0	0	0	61.00
62.00	FUNDRAI SI NG	0	0		0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0	0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES	0	0		0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTI SI NG	0	0		0	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0	0	0	68.00
69.00	THRIFT STORE	0	0		U	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0		0	~	0	70.00 71.00
71.00 99.00	OTHER NONREI MBURSABLE (SPECI FY) NEGATI VE COST CENTER	0	0		0	0	0	71.00 99.00
	TOTAL	1, 399, 131	0		0	167, 145	1, 399, 131	
100.00		1, 377, 131	0	I	Ч	107, 145	1, 377, 131	100.00

		HENRY COUNTY MEM					u of Form CMS		2-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C	CN: 15-0030	Pe	eriod: com 01/01/2020	Worksheet O- Part I	6	
			Hospi ce CC	N: 15-1564	To		Date/Time Pr	epare	ed:
							7/30/2021 9:	15 an	m
						Hospi ce I			
	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &		HOUSEKEEPI NG	DI ETARY		
		E & GENERAL	OPERATION &	LINEN SERVI	CE				
		1.00	MAINTENANCE	( 00		7.00	0.00	_	
	OFNERAL CERVILOE COCT OFNEEDC	4.00	5.00	6.00		7.00	8.00		
1 00	GENERAL SERVICE COST CENTERS			1		I		1	00
1.00	CAP REL COSTS-BLDG & FIXT								. 00
2.00 3.00	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT								2.00 8.00
3.00 4.00	ADMINI STRATI VE & GENERAL	(E7 1E2							. 00
4.00 5.00	PLANT OPERATION & MAINTENANCE	657, 153 119, 393	254 107	,					i. 00
5.00 6.00	LAUNDRY & LINEN SERVICE	119, 393	254, 197		0				5.00 5.00
7.00	HOUSEKEEPING	0	0		0	0			. 00 . 00
7.00 8.00	DI ETARY	0	0			0			. 00 3. 00
8.00 9.00	NURSI NG ADMI NI STRATI ON	0	0			0			9.00 9.00
7.00 10.00	ROUTI NE MEDI CAL SUPPLI ES	2, 128	0			0			). 00
11.00	MEDICAL RECORDS	3, 754	0			0			. 00
12.00	STAFF TRANSPORTATION	3,734	0			0			2.00
12.00	VOLUNTEER SERVICE COORDINATION	0	0			0			. 00 . 00
14.00	PHARMACY	0	0			0			. 00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0	0	,		0			5. 00
16.00	OTHER GENERAL SERVICE	0	0			0			. 00 . 00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	0			0			. 00 . 00
17.00	LEVEL OF CARE			1		0			. 00
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.	0. 00
51.00	HOSPICE ROUTINE HOME CARE	526, 641							. 00
52.00	HOSPICE INPATIENT RESPITE CARE	2, 793	135, 571		0	o			. 00
53.00	HOSPICE GENERAL INPATIENT CARE	2, 444	118, 626	•	0	0		0 53.	. 00
	NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0	)		0		60.	0. 00
61.00	VOLUNTEER PROGRAM	0	0			0		61.	. 00
62.00	FUNDRAI SI NG	0	0			0		62.	. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.	. 00
64.00	PALLIATIVE CARE PROGRAM	0	0	)		0		64.	. 00
65.00	OTHER PHYSICIAN SERVICES	0	0	)		0		65.	6.00
66.00	RESI DENTI AL CARE	0	0	)	0	0		0 66.	. 00
67.00	ADVERTI SI NG	0	0			0		67.	. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0			0			8.00
69.00	THRI FT STORE	0	0			0			0. 00
70.00	NURSING FACILITY ROOM & BOARD								0. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0			. 00
99.00	NEGATIVE COST CENTER	0	0		0	0			. 00
100 00	TOTAL	657, 153	254, 197		0	0		0 100.	. 00

Heal th	Financial Systems	IENRY COUNTY MEMO	RIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provider C	CN: 15-0030	Period:	Worksheet 0-6	5
			Hospi ce CCI	N: 15-1564	From 01/01/2020 To 12/31/2020		narod
			nospi ce cci	N. 15-1504	10 12/31/2020	7/30/2021 9:1	ipareu. 15 am
					Hospi ce I	110072021 7.	
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI O	MEDI CAL	RECORDS	TRANSPORTATI 0		
		N	SUPPLI ES		Ν	COORDI NATI ON	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON	0					9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0	4, 531				10.00
11.00	MEDICAL RECORDS	0	1,001	7,9	93		11.00
12.00	STAFF TRANSPORTATION	0		,	, , , , , , , , , , , , , , , , , , , ,		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0					
	PHARMACY	0					
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				-	
	OTHER GENERAL SERVICE	0					
	PATI ENT/RESI DENTI AL CARE SERVI CES	0					17.00
17.00	LEVEL OF CARE						_ 17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	1	0 0		50.00
51.00	HOSPICE ROUTINE HOME CARE	0	4, 486				
52.00	HOSPICE INPATIENT RESPITE CARE	0	4,400		42 0	-	
53.00	HOSPICE GENERAL INPATIENT CARE	0	24		37 0		
55.00	NONREI MBURSABLE COST CENTERS	0	21		57		55.00
60,00	BEREAVEMENT PROGRAM	0			0		60.00
61.00	VOLUNTEER PROGRAM	0					
62.00	FUNDRALSING	0					
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0					
64.00	PALLIATIVE CARE PROGRAM	0			(	-	
65.00	OTHER PHYSICIAN SERVICES						
66.00	RESI DENTI AL CARE	0					
67.00	ADVERTI SI NG					-	
68.00	TELEHEALTH/TELEMONI TORI NG	0				-	
	THRI FT STORE	0					
70.00	NURSING FACILITY ROOM & BOARD	0				í í	70.00
	OTHER NONREIMBURSABLE (SPECIFY)				C		
99.00	NEGATI VE COST CENTER	0	0		0 0		
	TOTAL	0	4, 531			-	100.00
100.00		l U	4, 001	7,9	75 U	ין U	1100.00

Health Financial Systems	HE	ENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - HOSPITAL-BASED	HOSPI CE GENERAL SE	ERVICE COSTS	Provider C Hospice CC	CN: 15-0030 N: 15-1564	Period: From 01/01/2020 To 12/31/2020		epared:
					Hospi ce I		
Descriptions		PHARMACY	PHYSI CI AN ADMI NI STRATI V E SERVI CES	OTHER GENERA SERVI CE	AL PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTER	RS						
1.00 CAP REL COSTS-BLDG & FIXT							1.00
2.00 CAP REL COSTS-MVBLE EQUIP							2.00
3.00 EMPLOYEE BENEFITS DEPARTMEN	NT						3.00
4.00 ADMINISTRATIVE & GENERAL							4.00
5.00 PLANT OPERATION & MAINTENA	NCE						5.00
6.00 LAUNDRY & LINEN SERVICE							6.00
7.00 HOUSEKEEPI NG							7.00
8.00 DI ETARY							8.00
9.00 NURSING ADMINISTRATION							9.00
10.00 ROUTINE MEDICAL SUPPLIES							10.00
11.00 MEDI CAL RECORDS							11.00
12.00 STAFF TRANSPORTATION							12.00
13.00 VOLUNTEER SERVICE COORDINA	TI ON						13.00
14.00 PHARMACY		0					14.00
15.00 PHYSICIAN ADMINISTRATIVE SI	ERVI CES	0	0				15.00
16.00 OTHER GENERAL SERVICE		0			0		16.00
17.00 PATIENT/RESIDENTIAL CARE SI	ERVI CES				0		17.00
LEVEL OF CARE							1
50.00 HOSPICE CONTINUOUS HOME CAR	RE	0	0		0	0	50.00
51.00 HOSPICE ROUTINE HOME CARE		0	0		0	1, 133, 659	51.00
52.00 HOSPICE INPATIENT RESPITE (	CARE	0	0		0 0	141, 584	52.00
53.00 HOSPICE GENERAL INPATIENT (	CARE	0	0		0 0	123, 888	53.00
NONREI MBURSABLE COST CENTER	RS						
60.00 BEREAVEMENT PROGRAM		0			0	0	60.00
61.00 VOLUNTEER PROGRAM		0			0	0	61.00
62. 00 FUNDRAI SI NG		0			0	0	62.00
63.00 HOSPICE/PALLIATIVE MEDICINI	E FELLOWS	0			0	0	63.00
64.00 PALLIATIVE CARE PROGRAM		0			0	0	64.00
65.00 OTHER PHYSICIAN SERVICES		0			0	0	65.00
66. 00 RESI DENTI AL CARE		0	0		0 0	0	66.00
67.00 ADVERTI SI NG		0			0	0	67.00
68.00 TELEHEALTH/TELEMONI TORI NG		0			0	0	68.00
69.00 THRIFT STORE		0			0	0	69.00
70.00 NURSING FACILITY ROOM & BO	ARD					0	70.00
71.00 OTHER NONREI MBURSABLE (SPEC	CI FY)	0	0		0 0	0	71.00
99.00 NEGATIVE COST CENTER		0	0		0 0	0	99.00
100. 00 TOTAL		0	0		0 0	1, 399, 131	100.00

Heal th	Financial Systems	HENRY COUNTY MEM	IORI AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERA	L SERVICE COSTS	Provider C	CN: 15-0030	Peri od:	Worksheet 0-6	
STATI S	TI CAL BASI S		lloopi oo CC	N. 1E 1E//	From 01/01/2020		norod.
			Hospi ce CC	N: 15-1564	To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
					Hospi ce I	1100/2021 7.1	
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE		ADMI NI STRATI V	
		& FIX	EQUI P	BENEFI TS	Ν	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
			VALUE)	(GROSS		COSTS)	
				SALARI ES)			
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS		1				
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	167, 1			3.00
4.00	ADMI NI STRATI VE & GENERAL	0	0		0 -657, 153		4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	134, 804	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	0	0		0 0	0	7.00
8.00	DI ETARY	0	0		0 0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0 0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0 0	2, 403	
11.00	MEDI CAL RECORDS	0	0		0 0	4, 239	11.00
12.00	STAFF TRANSPORTATI ON	0	0		0 0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.00
14.00	PHARMACY	0	0		0 0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0 0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE				-	-	
50.00	HOSPICE CONTINUOUS HOME CARE				0 0		50.00
51.00	HOSPICE ROUTINE HOME CARE			165, 5			
52.00	HOSPICE INPATIENT RESPITE CARE	0			78 0	3, 154	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		68 0	2,760	53.00
60.00	NONREI MBURSABLE COST CENTERS	0	0		0 0	0	60,00
60.00 61.00	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM	0			0 0		61.00
61.00	FUNDRALSING	0			0 0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0		64.00
64.00 65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	65.00
66.00	RESIDENTIAL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
69.00	THRIFT STORE	0	0				69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0		0 0	0	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0 0	0	70.00
	NEGATIVE COST CENTER	0			0	0	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Par	+ I) 0	n –	167, 1	45	657, 153	
	UNIT COST MULTIPLIER	0. 000000	0. 000000			0. 885677	
	· · · · · · · · · · · · · · · · · · ·	1 2.250000					1

Heal th	Financial Systems HE	ENRY COUNTY MEM	ORIAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provider C	CN: 15-0030	Period: From 01/01/2020	Worksheet 0-6 Part II	)
STATIS	TI CAL BASI S		Hospi ce CC	N: 15-1564	To 12/31/2020		
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI N		NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET	, ,	ADMI NI STRATI O	
		MAI NTENANCE	(IN-FACILITY		DAYS)		
		(SQUARE FEET)	DAYS)			(DI RECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	295, 900					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0			0		7.00
8.00	DI ETARY	0			0 0		8.00
9.00	NURSING ADMINISTRATION	0			0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0			0	0	10.00
11.00	MEDI CAL RECORDS	0			0	0	11.00
12.00	STAFF TRANSPORTATION	0			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0			0		17.00
	LEVEL OF CARE			1			
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	157, 813	0		0 0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	138, 087	0		0 0	0	53.00
	NONREI MBURSABLE COST CENTERS			1			1 / 0 . 00
60.00	BEREAVEMENT PROGRAM	0			0	0	
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRALSING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0	0		0 0	-	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00 70.00	THRIFT STORE	0			U	0	69.00 70.00
70.00 71.00	NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	
71.00 99.00	NEGATIVE COST CENTER	0	0		0		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	254, 197	_		0		100.00
	UNIT COST MULTIPLIER	0. 859064	0. 000000	0,0000	0 0.00000	-	
101.00		0.007004	0.00000	0.0000	0.00000	0.00000	1.01.00

Heal th	Financial Systems HI	ENRY COUNTY MEM	IORI AL HOSPI TAL		In Lie	u of Form CMS	-2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI	ERVICE COSTS	Provider C	CN: 15-0030	Peri od:	Worksheet 0-	6
STATI S	TI CAL BASI S				From 01/01/2020	Part II	
			Hospi ce CC	N: 15-1564	To 12/31/2020	Date/Time Pr 7/30/2021 9:	
					Hospi ce I	773072021 9.	
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI V	SERVI CE	RESI DENTI AL	_		
		E SERVICES	(SPECI FY	CARE SERVICE			
		(PATI ENT	BASIS)	(IN-FACILIT			
		DAYS)	, í	DAYS)			
		15.00	16.00	17.00			
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0					15.00
16.00	OTHER GENERAL SERVICE		0				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	0					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0			0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0		53.00
	NONREIMBURSABLE COST CENTERS	İ	1	1			_
60.00	BEREAVEMENT PROGRAM		0				60.00
61.00	VOLUNTEER PROGRAM		0				61.00
62.00	FUNDRAI SI NG		0				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63.00
64.00	PALLIATIVE CARE PROGRAM		0				64.00
65.00	OTHER PHYSICIAN SERVICES		0				65.00
66.00	RESI DENTI AL CARE	0	0		0		66.00
67.00	ADVERTI SI NG		0				67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0	1			68.00
69.00	THRI FT STORE		0				69.00
70.00	NURSING FACILITY ROOM & BOARD		_		-		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0		71.00
	NEGATIVE COST CENTER	_	_				99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I) UNIT COST MULTIPLIER	0. 000000	0. 000000	0,0000	0		100. 00 101. 00
101.00	UNIT COST MULTIFLIER	0.00000	0.00000	J 0.0000			101.00

	ancial Systems MENT OF HOSPITAL-BASED HOSPICE SHARED SE	HENRY COUNTY MEM	Provi der C		Period:	u of Form CMS-: Worksheet 0-7	
EVEL OF C				N: 15-1564	From 01/01/2020 To 12/31/2020		pared:
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	НСНС	HRHC	HI RC	
		0	1.00	2.00	3.00	4.00	
	I LLARY SERVICE COST CENTERS				-		
	SI CAL THERAPY	66.00			0 0	0	
	UPATIONAL THERAPY	67.00			0 0	0	
	ECH PATHOLOGY GS CHARGED TO PATI ENTS	68.00 73.00	0. 674580 0. 429626		0 0	0	
	ABLE MEDICAL EQUIP-RENTED	73.00 96.00	0. 429020		0 0	0	5.00
	ORATORY	98.00 60.00	0. 187495		0 0	0	
	OD LABORATORY	60.00	0. 187495		0 0	0	
	I CAL SUPPLIES CHARGED TO PATIENTS	71.00	0. 170158		0 0	0	
	ER OUTPATIENT SERVICE COST CENTER	93.00	0. 170130		0	0	8.0
	I OLOGY-THERAPEUTI C	55.00					9.0
	DI AC REHAB	76.00	0. 279163		0 0	0	
1.00 Tot	als (sum of lines 1–11)						11.0
		Charges by		Shared Serv	ice Costs by LOC		
		LOC (from					
		Provi der					
		Records)			1 11 00 () 1	1101 D ( 1	
	Cost Center Descriptions	HGI P	HCHC (col. 1 x col. 2)	HRHC (col. x col. 3)	1 HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	<u>6,00</u>	7.00	8, 00	<u> </u>	
ANC	ILLARY SERVICE COST CENTERS	5.00	0.00	7.00	0.00	9.00	
	SI CAL THERAPY	0	0		0 0	0	1 1.0
	UPATIONAL THERAPY	0	0		0 0	0	2.0
00 SPE	ECH PATHOLOGY	0	0		0 0	0	3.0
00 DRU	GS CHARGED TO PATIENTS	0	0		0 0	0	4.C
	ABLE MEDICAL EQUIP-RENTED						5.0
	ORATORY	0	0		0 0	0	
	OD LABORATORY	0	0		0 0	0	
	I CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
	ER OUTPATIENT SERVICE COST CENTER						8.0
	I OLOGY-THERAPEUTI C					-	9.0
	DIAC REHAB	0	0		0 0	0	
ι. υυ μιστ	als (sum of lines 1–11)	I	0		0 0	0	11.0

ALCUL	ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provider CO	CN: 15-0030		i od:	Worksheet 0-8	
		Hospi ce CC	N: 15-1564	To	om 01/01/2020 12/31/2020	Date/Time Pre 7/30/2021 9:1	
					Hospi ce I		
			TITLE XVIII		TITLE XIX	TOTAL	
			MEDI CARE		MEDI CAI D		
			1.00		2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE						
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	-7, col. 6,				0	1.
	line 11)						
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 10)					0	
. 00	Total average cost per diem (line 1 divided by line 2)					0.00	
. 00	Unduplicated program days (Wkst. S-9 col. as appropriate, lir	ne 10)		0	0		4.
00	Program cost (line 3 times line 4)			0	0		5.
	HOSPICE ROUTINE HOME CARE						
00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	-7, col. 7,				1, 133, 659	6.
	line 11)						_
00	Total unduplicated days (Wkst. S-9, col. 4, line 11)					4, 525	7
00	Total average cost per diem (line 6 divided by line 7)					250. 53	8
00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	3, 4		0		9.
0. 00	Program cost (line 8 times line 9)		876, 1	03	0		10.
~ ~	HOSPICE INPATIENT RESPITE CARE	7 1 0		-		444 504	
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	-/, col. 8,				141, 584	11.
	line 11)					24	10
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)						12
. 00	Total average cost per diem (line 11 divided by line 12)	10)		~ 4		5, 899. 33	
. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne IZ)		24	0		14 15
6.00	Program cost (line 13 times line 14) HOSPICE GENERAL INPATIENT CARE		141, 5	84	U		1 15.
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	7 col 0			1	123, 888	14
. 00	lline 11)	-7, COL. 9,				123,000	10.
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)					21	17
. 00	Total average cost per diem (line 16 divided by line 17)					5, 899. 43	
. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)		21	0	5, 077. 45	19
	Program cost (line 18 times line 19)	110 10)	123, 8		0		20
. 00	TOTAL HOSPICE CARE		123,0	50	9		20
. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)					1, 399, 131	21
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)					4, 570	
2. UU							

ALCULATION OF CAPIT	L PAYMENT	Provi der CCN: 15-0030	Period: From 01/01/2020 To 12/31/2020		pareo
		Title XVIII	Hospi tal	PPS	o alli
				1.00	
PART I - FULLY	PROSPECTI VE METHOD				
CAPI TAL FEDERA					
	her than outlier			577, 163	
	apital DRG other than outlier			0	
	tlier payments			5, 135	
	apital DRG outlier payments			0	· -·
	t days divided by number of days in the	cost reporting period (see ins	tructions)	21.58	
	rns & residents (see instructions)	<b>`</b>		0.00	
	al education percentage (see instruction			0.00	
	al education adjustment (multiply line {	5 by the sum of lines 1 and 1.0	1, columns 1 and	0	6.
1.01) (see inst				0.00	-
00 Percentage of 30) (see instr	SSI recipient patient days to Medicare F	Part à patient days (worksneet	E, part A line	0.00	7.
	Medicaid patient days to total days (see	a instructions)		0.00	8.
00 Sum of lines 7				0.00	
	roportionate share percentage (see instr	ructions)		0.00	
	te share adjustment (see instructions)			0.00	
	ive capital payments (see instructions)			582, 298	
	The capital payments (see thistidetrons)			502, 270	12.
				1.00	
PART II - PAYM	ENT UNDER REASONABLE COST				
00 Program inpati	ent routine capital cost (see instruction	ons)		0	1.
00 Program inpati	ent ancillary capital cost (see instruct	tions)		0	2.
00 Total inpatier	t program capital cost (line 1 plus line	e 2)		0	3.
00 Capital cost p	ayment factor (see instructions)			0	4.
00 Total inpatier	t program capital cost (line 3 x line 4)	)		0	5.
	PUTATION OF EXCEPTION PAYMENTS			1.00	
	ent capital costs (see instructions)			0	1 1.
	ent capital costs for extraordinary circ	cumstances (see instructions)		0	
	patient capital costs (line 1 minus line			0	
	eption percentage (see instructions)	C 2)		0.00	
	for comparison to payments (line 3 x line	e 4)		0.00	
	ustment for extraordinary circumstances			0.00	
5 5	capital minimum payment level for extrac		x line 6)	0.00	
	m payment level (line 5 plus line 7)			0	
	apital payments (from Part I, line 12, a	as applicable)		0	
	omparison of capital minimum payment lev		less line 9)	0	
.00 Carryover of a	ccumulated capital minimum payment level art III, line 14)			0	
Worksheet L, F	of capital minimum payment level to cap	pital payments (line 10 plus li	ne 11)	0	12.
	exception payment (if line 12 is positive		,	0	
.00 Net comparisor				0	
2.00 Net comparison 6.00 Current year e 6.00 Carryover of a	ccumulated capital minimum payment level negative, enter the amount on this line	1 1 3	ron owning period	0	
2.00 Net comparison 3.00 Current year e 4.00 Carryover of a (if line 12 is	1 1 2	e)	rorrowing perrou	0	15.
2.00 Net comparisor 3.00 Current year e 4.00 Carryover of a (if line 12 is 5.00 Current year a	negative, enter the amount on this line	e) (see instructions)			

		NICT COUNTY MEM	ORIAL HOSPITAL			u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0030	Peri od:	Worksheet M-1	
			Component	CCN: 15-8520	From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	1, 517, 596	21, 843	1, 539, 43	-96, 423	1, 443, 016	1.00
2.00	Physician Assistant	0	0		0 0	0	2.00
3.00	Nurse Practitioner	631, 946	0	631, 94		641, 968	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	435, 284	60	435, 34	14 0	435, 344	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	79, 340	0	79, 34	40 0	79, 340	7.00
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	401, 835	0	401, 83	35 0	401, 835	9.00
10.00	Subtotal (sum of lines 1 through 9)	3, 066, 001	21, 903	3, 087, 90	-86, 401	3, 001, 503	10.00
11.00	Physician Services Under Agreement	0	0		0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
15.00	Medical Supplies	0	146, 713	146, 71	13 0	146, 713	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	53, 850	53, 85	50 0	53, 850	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	200, 563	200, 56	53 0	200, 563	21.00
22.00	Total Cost of Health Care Services (sum of	3, 066, 001	222, 466	3, 288, 46	-86, 401	3, 202, 066	22.00
	Lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23.00
	Dental	0	0		0 0	0	
24.00 25.00		0	0		0 0	0	
25.00	Optometry Telehealth	0	0			e e	
		0	0			0	
25.02	Chronic Care Management	0	0		0 0	-	
26.00	All other nonreimbursable costs	0	0		0 0	0	
27.00	Nonallowable GME costs		0			0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.00
	through 27)						
20.00	FACILITY OVERHEAD		E 40 50/	E40 50	24	E40 50(	20.00
29.00	Facility Costs	0 1 010 700	549, 586			549, 586	
30.00	Administrative Costs	1,018,723	1,060,535				
31.00	Total Facility Overhead (sum of lines 29 and	1, 018, 723	1, 610, 121	2, 628, 84	-693, 199	1, 935, 645	31.00
22.00	30) Tatal facility costs (our of lines 22, 20	4 004 704	1 000 507	E 017 01		E 107 744	
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,084,724	1, 832, 587	5, 917, 31	-779, 600	5, 137, 711	32.00

NALVS	Financial Systems HE IS OF HOSPITAL-BASED RHC/FOHC COSTS		Provider C		Peri od:	Worksheet M-	- <u>2552-1</u> 1
NAL I J				CCN: 15-8520	From 01/01/2020 To 12/31/2020	Date/Time Pro 7/30/2021 9:	epared:
-					RHC I	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6.00	7.00				
. 00	FACILITY HEALTH CARE STAFF COSTS Physician	0	1, 443, 016				1.0
. 00	Physician Assistant	0	1, 443, 010				2.0
. 00	Nurse Practitioner	0	641, 968				3.0
. 00	Visiting Nurse	0	041, 200				4.0
. 00	Other Nurse	0	435, 344				5.0
. 00	Clinical Psychologist	0	00,011				6.0
. 00	Clinical Social Worker	0	79, 340				7.0
. 00	Laboratory Techni ci an	0	0				8.0
. 00	Other Facility Health Care Staff Costs	0	401, 835				9.0
0.00	Subtotal (sum of lines 1 through 9)	0	3,001,503				10.0
1.00	Physician Services Under Agreement	0	0				11.0
2.00	Physician Supervision Under Agreement	0	0				12.0
3.00	Other Costs Under Agreement	0	0				13.0
4.00	Subtotal (sum of lines 11 through 13)	0	0				14.0
5.00	Medical Supplies	0	146, 713				15.0
6.00	Transportation (Health Care Staff)	0	0				16.0
	Depreciation-Medical Equipment	0	0				17.0
	Professional Liability Insurance	0	53, 850				18.0
	Other Health Care Costs	0	0				19.0
	Allowable GME Costs						20.0
1.00	Subtotal (sum of lines 15 through 20)	0	200, 563				21.0
2.00	Total Cost of Health Care Services (sum of	0	3, 202, 066				22.0
	Li nes 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						-
3.00	Pharmacy	0	0				23.0
3.00 4.00	Dental	0	-				23.0
5.00	Optometry	0					24.0
5.00	Tel eheal th	0	0				25.0
	Chronic Care Management	0	0				25.0
6.00	All other nonreimbursable costs	0	0				26.0
7.00	Nonallowable GME costs	0					27.0
8.00	Total Nonreimbursable Costs (sum of lines 23	0	l o				28.0
	through 27)						
	FACILITY OVERHEAD						
9.00	Facility Costs	-273, 932	275, 654				29.0
0.00	Administrative Costs	-172, 165					30.0
1.00	Total Facility Overhead (sum of lines 29 and	-446, 097	1, 489, 548				31.0
	30)						
2.00	Total facility costs (sum of lines 22, 28	-446,097	4, 691, 614	1			32.0

	Financial Systems HE		ORIAL HOSPITAL Provider C		Peri od:	u of Form CMS-2 Worksheet M-1	
ANALIS	IS OF HUSPITAL-DASED RHC/FURC CUSTS		Provider C	CN. 15-0030	From 01/01/2020	WULKSHEEL M-1	
			Component	CCN: 15-8525	To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
	· · · · · · · · · · · · · · · · · · ·				RHC II	Cost	
		Compensati on	Other Costs		1 Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	2.00	2.00	4.00	<u>col. 4)</u> 5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1.00	Physician	3, 497, 790	27, 471	3, 525, 2	61 96, 423	3, 621, 684	1.00
2.00	Physician Assistant	3, 477, 770	27,471	5, 525, 2	0 70, 423	0, 021, 004	2.00
3.00	Nurse Practitioner	1,838,609	0	1, 838, 6	0	1, 838, 609	3.00
4.00	Visiting Nurse	1, 030, 007	0	1,030,0	0 0	1, 030, 007	4.00
5.00	Other Nurse	364, 394	0	364, 3	0 0	364, 394	
5.00	Clinical Psychologist	504, 574	0	504, 5	<sup>74</sup> 0	0	
7.00	Clinical Social Worker	0	43, 510	43, 5	10 66, 304	109, 814	
3.00 3.00	Laboratory Techni ci an	0	43, 510	43, 5	0 00, 304	09,814	
5.00 7.00	Other Facility Health Care Staff Costs	1,009,854	0	1, 009, 8	0 0 E4 0	1, 009, 854	
10.00	Subtotal (sum of lines 1 through 9)	6, 710, 647	70, 981	6, 781, 6		6, 944, 355	
11.00	Physician Services Under Agreement	0, 710, 047	70, 961	0,701,0	0 102, 727	0, 944, 355	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	
	5	0	0		0 0	-	
13.00 14.00	Other Costs Under Agreement Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
14.00		0	427 502	407 5	0 0	-	
	Medical Supplies	0	437, 502	437, 5	J2 0	437, 502	
16.00	Transportation (Health Care Staff)	0	0		0 0	0	
17.00	Depreciation-Medical Equipment	0	0		0 0	0	
18.00	Professional Liability Insurance	0	0		0 0	0	
19.00	Other Health Care Costs	0	0		0 0	0	
20.00	Allowable GME Costs		407 500	407 5		407 500	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	437, 502			437, 502	
22.00	Total Cost of Health Care Services (sum of	6, 710, 647	508, 483	7, 219, 1	30 162, 727	7, 381, 857	22.00
	l i nes 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	
25.00	Optometry	0	0		0 0	0	
25.00	Tel eheal th	0	0		0 0	0	
25.01	Chronic Care Management	0	0		0 0	0	
	All other nonreimbursable costs	0	0		0 0	0	
26.00		0	0		0 0	0	
27.00	Nonallowable GME costs	0	0		0	0	27.00 28.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		0 0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	1, 439, 634	1, 439, 6	34 0	1, 439, 634	29.00
30.00	Administrative Costs	860, 136	1, 439, 034			1, 439, 834	
31.00	Total Facility Overhead (sum of lines 29 and	860, 136	3, 109, 592			2, 866, 967	
51.00	30)	000, 130	3, 109, 392	3, 707, 7.	-1, 102, /01	2,000,907	31.00
32.00	Total facility costs (sum of lines 22, 28	7, 570, 783	3, 618, 075	11, 188, 8	-940, 034	10, 248, 824	32.00
2.00	and 31)	,, 5, 0, 705	5,010,075		- 740, 034	10, 240, 024	1 52.00

VALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0030	Peri od:	Worksheet M-	-1
			Component (	CCN: 15-8525	From 01/01/2020 To 12/31/2020	Date/Time Pr 7/30/2021 9:	
					RHC II	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		(	col. 6)				
		6.00	7.00				-
00	FACILITY HEALTH CARE STAFF COSTS	1 201 200	2 220 274				1
00	Physician	-1, 291, 308	2, 330, 376				
00 00	Physician Assistant Nurse Practitioner	0	1 020 (00				2
00	Visiting Nurse	0	1, 838, 609				4
00	Other Nurse	0	364, 394				5.
00	Clinical Psychologist	0	۵04, ۵ <del>9</del> 4 ۸				6
00	Clinical Social Worker	0	109, 814				7
00	Laboratory Techni ci an	0	109, 614				8
00	Other Facility Health Care Staff Costs	0	1,009,854				9
), 00	Subtotal (sum of lines 1 through 9)	-1, 291, 308	5, 653, 047				10
. 00	Physician Services Under Agreement	-1, 291, 300	3,033,047 0				11
	Physician Supervision Under Agreement	0	0				12
	Other Costs Under Agreement	0	0				13
I. 00	Subtotal (sum of lines 11 through 13)	0	0				14
	Medical Supplies	0	437, 502				15
	Transportation (Health Care Staff)	0	437, 302				16
7.00	Depreciation-Medical Equipment	0	0				17
	Professional Liability Insurance	0	0				18
	Other Health Care Costs	0	0				19
	Allowable GME Costs	0	0				20
1.00	Subtotal (sum of lines 15 through 20)	0	437, 502				21
	Total Cost of Health Care Services (sum of	-1, 291, 308	6,090,549				22
	lines 10, 14, and 21)	1, 271, 000	0,070,017				122
	COSTS OTHER THAN RHC/FQHC SERVICES						
. 00	Pharmacy	0	0				23
. 00	Dental	0	0				24
5.00	Optometry	0	0				25
5. 01	Tel eheal th	0	0				25
5. 02	Chronic Care Management	0	0				25
5.00	All other nonreimbursable costs	0	0				26
7.00	Nonallowable GME costs						27
8.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28
	through 27)						
	FACILITY OVERHEAD						
0. 00	Facility Costs	-707, 983	731, 651				29
). 00	Administrative Costs	-306, 071	1, 121, 262				30
. 00	Total Facility Overhead (sum of lines 29 and	-1, 014, 054	1, 852, 913				31
	30)						
2.00	Total facility costs (sum of lines 22, 28	-2, 305, 362	7, 943, 462				32

Heal th	Financial Systems HE	NRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0030	Peri od:	Worksheet M-1	
			Component	CCN: 15-8556	From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
					RHC III	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat		
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS			•			
1.00	Physi ci an	24, 667	972	25, 63	39 0	25, 639	1.00
2.00	Physician Assistant	0	0		0 0		2.00
3.00	Nurse Practitioner	149, 734	0	149, 73	34 0	149, 734	3.00
4.00	Visiting Nurse	0	0		0 0	0	1
5.00	Other Nurse	20, 851	1	20, 85	52 0	20, 852	
6.00	Clinical Psychologist	20,001	0	20,00	0 0	0	
7.00	Clinical Social Worker	0	352	31	52 0	352	
8.00	Laboratory Techni ci an	0	0		0 0	0	
9.00	Other Facility Health Care Staff Costs	50, 635	0	50, 63	0	50, 635	
			-				
10.00	Subtotal (sum of lines 1 through 9)	245, 887	1, 325	247, 2		247, 212	
11.00	Physician Services Under Agreement	Ű	0		0 0	0	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	
13.00	Other Costs Under Agreement	0	0		0 0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
15.00	Medical Supplies	0	23, 088	23, 08		23, 088	
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
	Depreciation-Medical Equipment	0	0		0 0	0	
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23, 088	23, 08	38 0	23, 088	21.00
22.00	Total Cost of Health Care Services (sum of	245, 887	24, 413	270, 30	0 00	270, 300	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES					•	
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
25.01	Tel eheal th	0	0		0 0	0	25.01
25.02	Chronic Care Management	0	0		0 0	0	
26.00	All other nonreimbursable costs	0	0		0 0	0	
27.00	Nonallowable GME costs	0	0		0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	
20.00	through 27)	0	0		0 0	0	20.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	172, 489	172, 48	39 0	172, 489	29.00
29.00	Administrative Costs	-	172, 489				
		46, 541					
31.00	Total Facility Overhead (sum of lines 29 and	46, 541	292, 942	339, 48	33 -55, 257	284, 226	31.00
22.00	30) Tatal facility costs (our of lines 22, 20	202 422	047 055	(00 7			22.00
32.00	Total facility costs (sum of lines 22, 28	292, 428	317, 355	609, 78	33 -55, 257	554, 526	32.00
	and 31)	I		I	I	I	I

	Financial Systems HE IS OF HOSPITAL-BASED RHC/FQHC COSTS	NRY COUNTY MEN	Provider C		Period:	u of Form CMS- Worksheet M-1	
VALIS	TS OF HUSPITAL-BASED RHC/FUHC CUSTS		Provider C	CN: 15-0030	From 01/01/2020	worksneet M-	1
			Component	CCN: 15-8556	To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
					RHC III	Cost	15 am
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		6. 00	col. 6) 7.00				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
00	Physi ci an	0	25, 639				1 1.
00	Physician Assistant	0					2.
00	Nurse Practitioner	0	149, 734				3.
00	Visiting Nurse	0	0				4.
00	Other Nurse	0	20, 852				5.
00	Clinical Psychologist	0	0				6
00	Clinical Social Worker	0	352				7
00	Laboratory Techni ci an	0	0				8
00	Other Facility Health Care Staff Costs	0	50, 635				9
00	Subtotal (sum of lines 1 through 9)	0	247, 212				10
00	Physician Services Under Agreement	0	0				11
00	Physician Supervision Under Agreement	0	0				12
00	Other Costs Under Agreement	0	0				13
. 00	Subtotal (sum of lines 11 through 13)	0	0				14
. 00	Medical Supplies	0	23, 088				15
. 00		0	0				16
. 00	Depreciation-Medical Equipment	0	0				17
. 00	Professional Liability Insurance	0	0				18
. 00	Other Health Care Costs	0	0				19
. 00	Allowable GME Costs	0	22.000				20
. 00	Subtotal (sum of lines 15 through 20)	0					21
. 00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	270, 300				22
	COSTS OTHER THAN RHC/FQHC SERVICES						
. 00	Pharmacy	0	0				23
. 00	Dental	0					24
. 00	Optometry	0	0				25
. 01	Tel eheal th	0	0				25
. 02	Chronic Care Management	0	0				25
. 00	All other nonreimbursable costs	0	0				26
. 00	Nonallowable GME costs						27
. 00	Total Nonreimbursable Costs (sum of lines 23	0	0				28
	through 27)						
	FACILITY OVERHEAD			1			-
	Facility Costs	-120, 917					29
. 00	Administrative Costs	0	111, 737				30
. 00	Total Facility Overhead (sum of lines 29 and	-120, 917	163, 309				31
. 00	30) Total facility costs (sum of lines 22, 29	100 017	122 400				20
. 00	Total facility costs (sum of lines 22, 28	-120, 917	433, 609	1			32

lealth Financial Systems	HENRY COUNTY ME				u of Form CMS-2	
ALLOCATION OF OVERHEAD TO HOSPITAL-BA	SED RHC/FQHC SERVICES	Provider (		Period: From 01/01/2020	Worksheet M-2	
		Component		To 12/31/2020		pared
					7/30/2021 9:1	5 am
			1	RHC I	Cost	
	Number of FTI	E Total Visits			Greater of	
	Personnel		Standard (1)		col. 2 or	
				1 x col. 3)	col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						-
Positions		-	1		1	
. 00 Physi ci an	3.8			1 4		1.0
.00 Physician Assistant	0.5			1 1		2.0
.00 Nurse Practitioner	2.9			1 3		3.0
.00 Subtotal (sum of lines 1 throug				8	19, 053	
00 Visiting Nurse	0.0		D		0	
00 Clinical Psychologist	0.0		D		0	6.
.00 Clinical Social Worker	0.8				1, 049	
.01 Medical Nutrition Therapist (FG	57		כ		0	
.02 Diabetes Self Management Traini	ng (FQHC 0.0	0 (	D		0	7.
onl y)						
.00 Total FTEs and Visits (sum of I	ines 4 8.3	0 20, 102	2		20, 102	8.0
through 7)						
. 00 Physician Services Under Agreer	ents	(			0	9.0
					1.00	<u> </u>
DETERMINATION OF ALLOWABLE COST	APPLI CABLE TO HOSPI TAL-BA	SED RHC/FQHC SE	RVI CES		1.00	
0.00 Total costs of health care serv					3, 202, 066	1 10.0
1.00 Total nonreimbursable costs (fi					0	
2.00 Cost of all services (excluding					3, 202, 066	
3.00 Ratio of hospital-based RHC/FQ					1.000000	
. 00 Total hospital-based RHC/FQHC (		, , , , , , , , , , , , , , , , , , ,	ine 31)		1, 489, 548	
5.00 Parent provider overhead alloca					3, 704, 549	
5.00 Total overhead (sum of lines 14					5, 194, 097	
7.00 Allowable GME overhead (see ins					0	
8.00 Enter the amount from line 16					5, 194, 097	
9.00 Overhead applicable to hospital	-based RHC/EOHC services (	line 13 x line	18)		5, 194, 097	
0.00 Total allowable cost of besnit					0 206 162	

20.00 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19)

Health Financial Systems	HENRY COUNTY ME				u of Form CMS-2	
ALLOCATION OF OVERHEAD TO HOSPITAL-BASE	D RHC/FQHC SERVICES	Provider C		Period: From 01/01/2020	Worksheet M-2	
		Component		To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
				RHC II	Cost	
	Number of FTE	Total Visits			Greater of	
	Personnel		Standard (1)	Visits (col.	col. 2 or	
				1 x col. 3)	col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Posi ti ons						
. 00 Physi ci an	6. 21			1 6		1.0
. 00 Physician Assistant	0.00			1 0		2.0
.00 Nurse Practitioner	10. 53	3 24, 301		1 11		3.0
.00 Subtotal (sum of lines 1 through	3) 16.74	45, 598	8	17	45, 598	4.0
.00 Visiting Nurse	0.00	) C	)		0	5.0
.00 Clinical Psychologist	0.00	) C	)		0	6.0
.00 Clinical Social Worker	0.64	1, 058	6		1, 058	7.0
.01 Medical Nutrition Therapist (FQH	C only) 0.00	0 0			0	7.0
. 02 Diabetes Self Management Trainin	g (FQHC 0.00				0	7.0
onl y)	_					
.00 Total FTEs and Visits (sum of li	nes 4 17.38	3 46, 656			46, 656	8.0
through 7)						
0.00 Physician Services Under Agreeme	nts	C	)		0	9.0
					1.00	
DETERMINATION OF ALLOWABLE COST	APPLI CABLE TO HOSPI TAL-BAS	ED RHC/FQHC SE	RVI CES		1.00	
0.00 Total costs of health care servi	ces (from Wkst. M-1, col.	7, line 22)			6, 090, 549	10.0
1.00 Total nonreimbursable costs (fro					0	11.0
2.00 Cost of all services (excluding		,			6,090,549	12.0
3.00 Ratio of hospital-based RHC/FQHC					1.000000	
1.00 Total hospital-based RHC/FQHC ov		· · ·	ine 31)		1, 852, 913	14.0
5.00 Parent provider overhead allocat			- /		7,002,129	
5.00 Total overhead (sum of lines 14		/			8, 855, 042	
7.00 Allowable GME overhead (see inst					0,000,012	
3.00 Enter the amount from line 16					8, 855, 042	
9.00 Overhead applicable to hospital-	pased RHC/FQHC services (1	ine 13 x line	18)		8, 855, 042	
0.00 Total allowable cost of bespital					14 045 501	

20. 00 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19) 14,945,591 20.00

		ENRY COUNTY MEN				u of Form CMS-2	
ALLOCATI (	ON OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Period: From 01/01/2020	Worksheet M-2	
			Component	CCN: 15-8556	To 12/31/2020	Date/Time Pre	pared:
						7/30/2021 9:1	
					RHC III	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
	SITS AND PRODUCTIVITY						-
	ositions			1			
	hysi ci an	0.07			1 0		1.0
	hysician Assistant	0.00			1 0		2.0
	urse Practitioner	0. 91			1 1		3. C
	ubtotal (sum of lines 1 through 3)	0. 98			1	1, 879	4.0
	isiting Nurse	0.00				0	5.0
	linical Psychologist	0.00				0	6.0
	linical Social Worker	0.00				0	7.0
	edical Nutrition Therapist (FQHC only)	0.00				0	7.0
	iabetes Self Management Training (FQHC	0.00	0			0	7.0
	nl y)						
	otal FTEs and Visits (sum of lines 4	0. 98	1, 879			1, 879	8.0
	hrough 7)					_	
. 00 Ph	hysician Services Under Agreements		0			0	9.0
						1.00	
DE	TERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPI TAL-BASI	ED RHC/FQHC SE	RVI CES		1.00	
D. 00 To	otal costs of health care services (from W	kst. M-1, col.	7, line 22)			270, 300	10.0
1. 00 To	otal nonreimbursable costs (from Wkst. M-1	col. 7, line	28)			0	11.0
2. 00 Co	ost of all services (excluding overhead) (	sum of lines 10	and 11)			270, 300	12.0
	atio of hospital-based RHC/FQHC services (					1.000000	13.0
1. 00 To	otal hospital-based RHC/FQHC overhead - (fi	rom Worksheet.	M-1, col. 7, I	ine 31)		163, 309	14.0
	arent provider overhead allocated to facil			,		346, 234	
	otal overhead (sum of lines 14 and 15)		,			509, 543	
	llowable GME overhead (see instructions)					0	
	nter the amount from line 16					509, 543	18.0
	verhead applicable to hospital-based RHC/F	QHC services (I	ine 13 x line	18)		509, 543	
	atal allowable cost of been tal based DUC/					770 042	

 20.00
 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19)
 779, 843
 20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR H	HOSPI TAL-BASED RHC/FQHC	Provider CCN: 15-0030	Peri od:	Worksheet M-3	8
SERVI CES		Component CCN: 15-8520	From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
		Title XVIII	RHC I	Cost	Jan
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BAS			i		
.00 Total Allowable Cost of hospital-based				8, 396, 163	
.00 Cost of vaccines and their administrat		ne 15)		241, 743	
.00 Total allowable cost excluding vaccine				8, 154, 420	
.00 Total Visits (from Wkst. M-2, column 5				20, 102	
.00 Physicians visits under agreement (fro		line 9)		0	
.00 Total adjusted visits (line 4 plus lin				20, 102	
.00 Adjusted cost per visit (line 3 divide	ed by line 6)			405.65	7.
			Calculation	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Period 1)	Period 2)	-
.00 Per visit payment limit (from CMS Pub.	100.04 chapter 0.520	A or your contractor	1.00	2.00	8
.00 Per visit payment limit (from CMS Pub. .00 Rate for Program covered visits (see i		. o or your contractor)	405.65	405.65	
CALCULATION OF SETTLEMENT			405.05	403.05	- 7
0.00 Program covered visits excluding menta	l health services (from	contractor records)	0	5, 914	1 10
1.00 Program cost excluding costs for menta	-		0	2, 399, 014	
2.00 Program covered visits for mental heal			0	2, 377, 014	
3.00 Program covered cost from mental healt	-	-	0	0	
4.00 Limit adjustment for mental health ser			0	0	
5.00 Graduate Medical Education Pass Throug					15
6.00 Total Program cost (sum of lines 11, 1			0	2, 399, 014	16
6.01 Total program charges (see instruction				1, 016, 449	
6.02 Total program preventive charges (see	instructions) (from prov	vider's records)		168, 369	
6.03 Total program preventive costs ((line	16.02/line 16.01) times	sline 16)		397, 382	16
6.04 Total Program non-preventive costs ((I	ine 16 minus lines 16.0	03 and 18) times .80)		1, 510, 872	16
(Titles V and XIX see instructions.)					
6.05 Total program cost (see instructions)			0	1, 908, 254	
7.00 Primary payer amounts				0	17
8.00 Less: Beneficiary deductible for RHC	only (see instructions)	(from contractor		113, 042	18
records)				4.47 000	10
9.00 Beneficiary coinsurance for RHC/FQHC s records)	ervices (see instruction	ons) (from contractor		147, 008	19
0.00 Net Medicare cost excluding vaccines (	see instructions)			1, 908, 254	20
1.00 Program cost of vaccines and their adm	inistration (from Wkst.	M-4, line 16)		87, 118	21
2.00 Total reimbursable Program cost (line	20 plus line 21)			1, 995, 372	22
3.00 Allowable bad debts (see instructions)				0	
3.01 Adjusted reimbursable bad debts (see i				0	
4.00 Allowable bad debts for dual eligible		ructions)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (				0	
5.50 Pioneer ACO demonstration payment adju		is)		0	
5.99 Demonstration payment adjustment amoun				0	
6.00 Net reimbursable amount (see instructi				1, 995, 372	
6.01 Sequestration adjustment (see instruct	-			13, 169	
6.02 Demonstration payment adjustment amoun	it after sequestration			1 222 502	
7.00  Interim payments 8.00  Tentative settlement (for contractor u				1, 233, 503	
	57	$02 \ 27 \ and \ 29$		0	
9.00 Balance due component/program (line 26 0.00 Protested amounts (nonallowable cost r				748, 700 0	
				0	1 30

ALCUL	Financial Systems HENRY COUNTY MEMORI ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	AL HOSPITAL Provider CCN: 15-0030	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI C	ES	Component CCN: 15-8525	From 01/01/2020 To 12/31/2020	Date/Time Pre	
				7/30/2021 9:1	5 am
		Title XVIII	RHC I I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	· · · · · ·		14, 945, 591	
. 00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		1, 133, 785	
. 00	Total allowable cost excluding vaccine (line 1 minus line 2)			13, 811, 806	
. 00	Total Visits (from Wkst. M-2, column 5, line 8)			46, 656	
. 00 . 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	TTHE 9)		0 46, 656	
. 00	Adjusted cost per visit (line 3 divided by line 6)			296.03	
. 00			Cal cul ati on		<u> </u>
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Period 1)	Period 2)	-
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	) 6 or your contractor)	1.00	2.00	8
. 00	Rate for Program covered visits (see instructions)		296.03	296.03	
. 00	CALCULATION OF SETTLEMENT		270.00	270.00	1 1
0.00	Program covered visits excluding mental health services (from	n contractor records)	0	6, 181	1 10
1.00	Program cost excluding costs for mental health services (line	e 9 x line 10)	0	1, 829, 761	11
2.00	Program covered visits for mental health services (from contr	actor records)	0	0	
3.00	Program covered cost from mental health services (line 9 x li		0	0	
4.00	Limit adjustment for mental health services (see instructions		0	0	
5.00	Graduate Medical Education Pass Through Cost (see instruction		0	1 000 7/1	15
6. 00 6. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re		0	1, 829, 761 1, 183, 819	
6. 02	Total program preventive charges (see instructions)(from contractor s re	·		291, 988	
6.03	Total program preventive costs ((line 16.02/line 16.01) times			451, 309	
6.04	Total Program non-preventive costs ((line 16 minus lines 16.0			1,003,090	
	(Titles V and XIX see instructions.)				
6. 05	Total program cost (see instructions)		0	1, 454, 399	
7.00	Primary payer amounts			0	
8.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		124, 590	18
9.00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		152, 955	19
7.00	records)			152, 955	' 7
0. 00	Net Medicare cost excluding vaccines (see instructions)			1, 454, 399	20
1.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		154, 041	21
2.00	Total reimbursable Program cost (line 20 plus line 21)			1, 608, 440	22
3.00	Allowable bad debts (see instructions)			0	
3.01	Adjusted reimbursable bad debts (see instructions)			0	
4.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5.00 5.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction			0	
5.90 5.99	Demonstration payment adjustment amount before sequestration	13)		0	
6.00	Net reimbursable amount (see instructions)			1, 608, 440	
6. 01	Sequestration adjustment (see instructions)			10, 616	
6. 02	Demonstration payment adjustment amount after sequestration			0	
7.00	Interim payments			1, 172, 855	
8.00	Tentative settlement (for contractor use only)			0	
	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		424, 969	29
9.00 0.00	Protested amounts (nonallowable cost report items) in accorda			0	30

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	IAL HOSPITAL Provider CCN: 15-0030	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVICES	Component CCN, 15, 0554	From 01/01/2020	Data /Tima Dra	
	Component CCN: 15-8556	To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
	Title XVIII	RHC III	Cost	
DETERMINATION OF DATE FOR HOCDITAL DACED DUG (FOUG CERVILOFO			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (fro	www.ct M 2 Lipo 20)		779, 843	1 1.
.00  Total Allowable Cost of hospital-based RHC/FQHC Services (fro .00  Cost of vaccines and their administration (from Wkst. M-4, li	· · · · · ·		27,469	
.00 Total allowable cost excluding vaccine (line 1 minus line 2)	The TS)		752, 374	3.
.00 Total Visits (from Wkst. M-2, column 5, line 8)			1,879	
.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		1, 0/ 7	
.00 Total adjusted visits (line 4 plus line 5)	Title 9)		1,879	
.00 Adjusted cost per visit (line 3 divided by line 6)			400. 41	7.
		Cal cul ati on		/.
		Prior to Jan.	On or After	
		1 (Rate	Jan. 1 (Rate	
		Period 1)	Period 2)	
		1.00	2.00	-
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	).6 or your contractor)	0.00	0.00	
.00 Rate for Program covered visits (see instructions)		400. 41	400. 41	9.
CALCULATION OF SETTLEMENT			240	1 10
0.00 Program covered visits excluding mental health services (from		0	248	
1.00 Program cost excluding costs for mental health services (line	•	0	99, 302	
2.00 Program covered visits for mental health services (from contr	-	0	0	
3.00 Program covered cost from mental health services (line 9 x li	-	0	0	
4.00 Limit adjustment for mental health services (see instructions 5.00 Graduate Medical Education Pass Through Cost (see instruction	-	0	0	14
5.00  Graduate Medical Education Pass Through Cost (see instruction 6.00  Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	99, 302	
6.01 Total program charges (see instructions)(from contractor's re		0	40, 884	
6.02 Total program preventive charges (see instructions) (from contractor s re	· ·		12, 434	
6.03 Total program preventive costs ((line 16.02/line 16.01) times			30, 201	
6.04 Total Program non-preventive costs ((line 16 minus lines 16.0			54, 482	
(Titles V and XIX see instructions.)			01, 102	'0.
6.05 Total program cost (see instructions)		0	84, 683	16.
7.00 Primary payer amounts			0	17.
8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		998	18.
records)				
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		5, 490	19.
records)				
0.00 Net Medicare cost excluding vaccines (see instructions)			84, 683	
1.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		6, 090	
2.00 Total reimbursable Program cost (line 20 plus line 21)			90, 773	
3.00 Allowable bad debts (see instructions)			0	23
3.01 Adjusted reimbursable bad debts (see instructions)			0	
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 5.50 Pioneer ACO demonstration payment adjustment (see instruction			0	25.
5.50 Pioneer ACO demonstration payment adjustment (see instruction 5.99 Demonstration payment adjustment amount before sequestration	15/		0	
6.00 Net reimbursable amount (see instructions)			90, 773	
6.01 Sequestration adjustment (see instructions)			90, 773 599	
6.02 Demonstration payment adjustment amount after sequestration			0	
7.00 Interim payments			13, 410	
8.00 Tentative settlement (for contractor use only)			13, 410	
9.00 Balance due component/program (line 26 minus lines 26.01, 26.	02. 27. and 28)		76, 764	
0.00 Protested amounts (nonallowable cost report items) in accorda			, 0, 704 0	
			0	1 30

Health F	Financial Systems HENRY COUNTY MEMORI	AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	TION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-0030	Period:	Worksheet M-4	
VACCI NE	COST	Component CCN: 15-8520	From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 9:1	
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
	Health care staff cost (from Wkst. M-1, col. 7, line 10)		3, 001, 503	3, 001, 503	1.00
	Ratio of pneumococcal and influenza vaccine staff time to tot			0.004240	
	Pneumococcal and influenza vaccine health care staff cost (li	,	2, 788	12, 726	
	Medical supplies cost - pneumococcal and influenza vaccine (f		36, 700	39, 980	
5.00 E	Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	39, 488	52, 706	5.00
6.00 1	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22	) 3, 202, 066	3, 202, 066	6.00
7.00 1	Total overhead (from Wkst. M-2, line 19)		5, 194, 097	5, 194, 097	7.00
8.00 F	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 012332	0.016460	8.00
C	divided by line 6)				
9.00 0	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	64, 054	85, 495	9.00
	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	103, 542	138, 201	10.00
11.00 1	Total number of pneumococcal and influenza vaccine injections	(from your records)	256	1, 169	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	404.46	118. 22	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin beneficiaries		109	364	13.00
14.00 F	Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)	heir) administration	44, 086	43, 032	14.00
15.00 1	Total cost of pneumococcal and influenza vaccine and its (the of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3			241, 743	15.00
16.00 T	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	its (their)		87, 118	16. 00

Heal th	Financial Systems HENRY COUNTY MEMORI	AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-0030	Peri od:	Worksheet M-4	
VACCIN	IE COST	Component CCN: 15-8525	From 01/01/2020 To 12/31/2020		
		Title XVIII	RHC II	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		5, 653, 047		1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,	18, 480		
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f		277, 545		
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	,	296, 025		
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22	· · · ·		
7.00	Total overhead (from Wkst. M-2, line 19)		8, 855, 042		
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6)	tal direct cost (line 5	0. 048604	0. 027257	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	430, 390	241, 362	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	726, 415	407, 370	10. 00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	1, 936	3, 795	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	375. 21	107.34	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin beneficiaries	istered to Program	206	715	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)	heir) administration	77, 293	76, 748	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (the of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3			1, 133, 785	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)			154, 041	16.00

Heal th	Financial Systems HENRY COUNTY MEMORI	AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-0030	Period:	Worksheet M-4	
VACCIN	IE COST	Component CCN: 15-8556	From 01/01/2020 To 12/31/2020		
		Title XVIII	RHC III	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		247, 212	247, 212	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,	229	963	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	5 /	4, 157	4, 172	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu		4, 386		
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22	· · ·		6.00
7.00	Total overhead (from Wkst. M-2, line 19)		509, 543		
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6)	tal direct cost (line 5	0. 016226	0. 018997	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	8, 268	9, 680	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	12, 654	14, 815	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	29	122	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1		436.34	121.43	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin beneficiaries	istered to Program	7	25	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)	heir) administration	3, 054	3, 036	14.00
15.00				27, 469	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	its (their)		6, 090	16.00

Heal th Fi	inancial Systems HENRY COUNTY ME	MORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
ANALYSI S	S OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-0030	Peri od:	Worksheet M-5	
SERVI CES	S RENDERED TO PROGRAM BENEFICIARIES		From 01/01/2020		
		Component CCN: 15-8520	To 12/31/2020		
			RHC I	7/30/2021 9:15 Cost	
	· · · · · · · · · · · · · · · · · · ·			T B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00 To	otal interim payments paid to hospital-based RHC/FQHC		1.00	1, 233, 503	1.00
	nterim payments payable on individual bills, either submi	itted or to be submitted to		0	2.00
	the contractor for services rendered in the cost reporting			-	
	NONE" or enter a zero	5 F ···································			
3.00 Li	ist separately each retroactive lump sum adjustment amount	nt based on subsequent			3.00
	evision of the interim rate for the cost reporting period				
	ayment. If none, write "NONE" or enter a zero. (1)				
Pr	rogram to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Pr	rovider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–			0	3.99
	otal interim payments (sum of lines 1, 2, and 3.99) (tra	nsfer to Worksheet M-3, line	e	1, 233, 503	4.00
	7)				
	O BE COMPLETED BY CONTRACTOR		- 1		
	ist separately each tentative settlement payment after de	esk review. Also show date c	of		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	rogram to Provider				F 01
5.01				0	5.01
5.02				0	5.02
5.03	novidor to Drogrom			0	5.03
5.50	rovider to Program			0	5.50
5.50				0	5.50
5.52				0	5.51
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-	5 08)		0	5.52 5.99
	Determined net settlement amount (balance due) based on th			0	6.00
	ETTLEMENT TO PROVIDER			748, 700	6.00
	ETTLEMENT TO PROGRAM			748,700	6.02
	otal Medicare program liability (see instructions)			1, 982, 203	7.00
7.00 10			Contractor	NPR Date	7.00
			NUMPER		
		0	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	

Heal th	Financial Systems HENRY COUNTY MEM	IORI AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	SIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR	Provider CCN: 15-0030	Peri od:	Worksheet M-5	
	ES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8525	From 01/01/2020 To 12/31/2020		
			RHC II	Cost	<u> </u>
				t B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			1, 172, 855	1.00
2.00	Interim payments payable on individual bills, either submithe contractor for services rendered in the cost reporting "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amoun revision of the interim rate for the cost reporting period				3.00
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program		-		
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54 3.99	Subtatal (our of lines 2 01 2 40 minus our of lines 2 50 2	00)		0	3.54 3.99
3.99 4.00	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3 Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)		)	1, 172, 855	3.99 4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after de	sk review. Also show date c	of		5.00
	each payment. If none, write "NONE" or enter a zero. (1) Program to Provider				
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
	Provider to Program				
5.50	Ŭ			0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5	. 98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER			424, 969	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			1, 597, 824	7.00
			Contractor	NPR Date	
		-	Number	(Mo/Day/Yr)	
		0	1.00	2.00	0.05
8.00	Name of Contractor	l	I		8.00

Health Financial Systems HENRY COUNTY MEM	IORI AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-0030	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8556	From 01/01/2020 To 12/31/2020		pared:
		RHC III	Cost	
			T B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC	· · · · ·		13, 410	1.00
2.00 Interim payments payable on individual bills, either submitthe contractor for services rendered in the cost reporting "NONE" or enter a zero			0	2.00
3.00 List separately each retroactive lump sum adjustment amoun revision of the interim rate for the cost reporting period	•			3.00
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider		-		
3. 01			0	3.01
3. 02			0	3.02
3. 03 3. 04			0	3. 03 3. 04
3. 05			0	3.04
Provi der to Program			0	3.05
3. 50			0	3.50
3. 51			0	3.50
3. 52			0	3.52
3. 53			0	3.53
3. 54			0	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3	. 98)		0	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (tran: 27)		9	13, 410	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after der each payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date o	of		5.00
Program to Provider		- 1		
5. 01			0	5.01
5. 02			0	5.02
5. 03			0	5.03
Provider to Program				F F0
5. 50			0	5.50
5. 51			0	5.51
5.52	00)		0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5 6.00 Determined net settlement amount (balance due) based on the			0	5.99 6.00
6.01 SETTLEMENT TO PROVIDER			76, 764	6.00 6.01
6.02 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM			70, 704	6.01
7.00 Total Medicare program liability (see instructions)			90, 174	7.00
		Contractor	NPR Date	7.00
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	