This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0005 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/26/2022 12:56 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/26/2022 Time: 12:56 pm Manually prepared cost report use only] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HENDRICKS REGIONAL HEALTH (15-0005) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Star	nton Risser	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Stanton Risser			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

		Ti tle XVIII				
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	693, 948	-13, 554	0	-846, 724	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
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
200. 00 Total	0	693, 948	-13, 554	0	-846, 724	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.

2.00	City: DANVILLE	State: IN	Zip Cod	e: 46122-	1409 Count	y: HENDRICK				2.00
		Component Name	CCN	CBSA	Provi der	Date	Paymer	nt Syst	em (P,	
			Number	Number	Type	Certified	Τ,	0, or	N)	
							V	XVIII	XIX	
		1. 00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	8. 00	
	Hospital and Hospital-Based Componer	nt Identification:		<u>'</u>	•			<u>' </u>		
3.00	Hospi tal	HENDRICKS REGIONAL	150005	26900	1	07/01/1966	N	Р	0	3.00
	<u>'</u>	HEALTH								
4.00	Subprovi der - IPF									4.00
5.00	Subprovi der - IRF									5.00
6. 00	Subprovider - (Other)									6.00
7. 00	Swing Beds - SNF									7. 00
8. 00	Swing Beds - NF									8.00
9. 00	Hospi tal -Based SNF									9. 00
10.00	! •									10.00
11. 00	· •									11.00
12. 00	· •									12.00
	Separately Certified ASC									13.00
14. 00					1	-				14.00
	• •									
	Hospital Based Health Clinic - RHC									15.00
	Hospital -Based Health Clinic - FQHC									16.00
	Hospi tal -Based (CMHC) I									17. 00
	Renal Dialysis									18. 00
19. 00	Other					L,				19. 00
						From:		То		
						1. 00		2. (00	
	Cost Reporting Period (mm/dd/yyyy)					01/01/2	021	12/31/	′2021	20.00
21.00	Type of Control (see instructions)					9				21.00
					1. 00	2. 00		3. 0	00	
	Inpatient PPS Information									
22.00	Does this facility qualify and is it	currently receiving pa	yments fo	r	Υ	N				22. 00
	disproporti onate share hospital adju	ustment, in accordance w	ith 42 CF	R						
	§412.106? In column 1, enter "Y" fo	or yes or "N" for no. Is	thi s							
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo	or yes or "N" for no.								
22. 01	Did this hospital receive interim ur		ts for th	is	Υ	Y				22. 01
	cost reporting period? Enter in colu									
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N									
	reporting period occurring on or aft									
22. 02	Is this a newly merged hospital that			re	N	N				22. 02
	payments to be determined at cost re	•			• •					
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob									
	or "N" for no, for the portion of the									
	October 1.	ie cost reportring perrou	on or ar							
22. 03		nic reclassification fro	m urhan t	_	N	N		N		22. 03
22.03	rural as a result of the OMB standar				IV	14		IV		22.03
	adopted by CMS in FY2015? Enter in a									
	for the portion of the cost reportir									
				- I						
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft									
	Does this hospital contain at least									
	counted in accordance with 42 CFR 41	12. 105)? Enter in corumn	3, Y I	01						
00.04	yes or "N" for no.									00.04
22. 04	Did this hospital receive a geograph				N	N		N		22. 04
	rural as a result of the revised OME									
	adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reportir			er						
	in column 2, "Y" for yes or "N" for	no for the portion of t	he cost							
	reporting period occurring on or aft	er October 1. (see inst	ructions)							
	Does this hospital contain at least	100 but not more than 4	99 beds (as						
	counted in accordance with 42 CFR 41	2.105)? Enter in colum	n 3, "Y"	for						
	yes or "N" for no.					1				
23.00	Which method is used to determine Me	edicaid days on lines 24	and/or 2	5		3 N				23. 00
	below? In column 1, enter 1 if date									
	if date of discharge. Is the method									
	reporting period different from the									
	reporting period? In column 2, ente									
		<u> </u>				•	,			•

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 12:56 pm In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3.00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 701 958 2,827 0 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 4, Medicaid HMO paid and eligible but unpaid days in 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/Rural S Date of Geogr 2.00 1.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26, 00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν Υ 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν N Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or 56.00 56.00 'N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

58.00

59.00

Ν

Ν

58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

	Financial Systems HENDRICI AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		ONAL HEALTH Provider CO		Peri od:	u of Form CMS-2 Worksheet S-2	
					From 01/01/2021 Fo 12/31/2021	Part I Date/Time Pre 5/26/2022 12:	pared: 56 pm
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1. 00	2. 00	3. 00	
50. 01	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 colis "Y", are you impacted by CR 11642 (or subsequent (adjustement? Enter "Y" for yes or "N" for no in colulf line 60 is yes, complete columns 2 and 3 for each	85? (s umn 1. CR) NAHI umn 2.	see If column 1 E MA payment	Y	Y 23. 00	1	60.00
	instructions)	Y/N	I ME	Direct GME	IME	Direct GME	
		1.00	2.00	2.00	4.00	F 00	
1 00	Did your hospital receive FTE slots under ACA	1.00	2. 00	3. 00	4. 00	5.00	61.00
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	
	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
1. 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
	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)						61.0
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61.0
	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)						61.0
1. 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)						61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1 10	06 the FTF- in line (1 0Fif) and a second		1. 00	2. 00	3. 00	4.00	/1 1
	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
1. 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. 2
						1. 00	
2.00	ACA Provisions Affecting the Health Resources and Sel Enter the number of FTE residents that your hospital	trai ned			riod for which	0.00	62.00
2. 01	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	a Teachi	0	, ,	o your hospital	0.00	62.0
	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se	er Sett	i ngs		peri od? Enter	N	63.00

Health Financial Systems	HENDRI C	KS REGIONAL HEALTH		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provi der CC		eriod: fom 01/01/2021 o 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/26/2022 12:	pared:
			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col . 2))	
			Si te 1.00	2. 00	3. 00	
Section 5504 of the ACA Base Yea	r FTE Residents in N	onprovider Settings				
period that begins on or after of the following seriod that begins on or after of the following seriod the first seriod the following seriod that the following seriod the following seriod the following seriod that the followin	0.00	0.00	0. 000000	64. 00		
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Si te		30.1 1,77	
45 00 Enter in column 1 if line 42	1. 00	2. 00	3.00	4. 00	5. 00	4E 00
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	0. 00		65.00
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col. 2))	
			Si te 1.00	2. 00	3. 00	
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Setting				
beginning on or after July 1, 20		ny aona maal dant	0.00	0.00	0.000000	44.00
66.00 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 (column 1 divided by (column 1 +	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	66.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0. 00	0. 00	0. 000000	67. 00

Enter "Y" for yes	or "N" for no			10
71.00 If line 70 is yes recent cost repor	Column 1: Did the facility have an approved GME teaching program in filed on or before November 15, 2004? Enter "Y" for yes or "N" for	no. (see	N	0 71
	[1)(iii)(c)) Column 2: Did this facility train residents in a new teac nnce with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for			
Column 3: If colu	nn 2 is Y, indicate which program year began during this cost reporting			
(see instructions	tation Facility PPS			
	on Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	N		75.
	er "Y" for yes and "N" for no.	the most N	N	0 76
	Column 1: Did the facility have an approved GME teaching program in ing period ending on or before November 15, 2004? Enter "Y" for yes o		I IN	0 / 70
	this facility train residents in a new teaching program in accordance			
	(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y agram year began during this cost reporting period. (see instructions)	'		
	<u> </u>	'		
Long Term Care Ho	enital PPS		1.0	0
0.00 Is this a long te	m care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	
I.00 Is this a LTCH co "Y" for yes and "	located within another hospital for part or all of the cost reporting	period? Enter	- N	81
TEFRA Providers	1 101 110.			
	oital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes establish a new Other subprovider (excluded unit) under 42 CFR Section		N	
§413. 40(f)(1)(ii)		86.		
7.00 Is this hospital	n extended neoplastic disease care hospital classified under section		N	87.
[1886(d)(1)(B)(VI)	P Enter "Y" for yes or "N" for no.	V	XIX	(
		1. 00	2.0	
Title V and XIX S	ervices / have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Y	90
yes or "N" for no	in the applicable column.			
	reimbursed for title V and/or XIX through the cost report either in Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91
	patients occupying title XVIII SNF beds (dual certification)? (see		N	92
	er "Y" for yes or "N" for no in the applicable column. operate an ICF/IID facility for purposes of title V and XIX? Enter	N	N	93.
	for no in the applicable column.	14		73.
1.00 Does title V or X applicable column	X reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94
	enter the reduction percentage in the applicable column.	0. 00	0.0	0 95
Does title V or X applicable column	X reduce operating cost? Enter "Y" for yes or "N" for no in the	N	N	96.
1	enter the reduction percentage in the applicable column.	0. 00	0.0	0 97
	X follow Medicare (title XVIII) for the interns and residents post ats on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	Υ	Y	98.
	e V, and in column 2 for title XIX.			
	X follow Medicare (title XVIII) for the reporting of charges on Wkst.	Υ	Y	98
title XIX.	" for yes or "N" for no in column 1 for title V, and in column 2 for			
	X follow Medicare (title XVIII) for the calculation of observation	Υ	Y	98
	D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 n column 2 for title XIX.			
	X follow Medicare (title XVIII) for a critical access hospital (CAH)	N	N	98.
	inpatient services cost? Enter "Y" for yes or "N" for no in column 1 n column 2 for title XIX.			
3.04 Does title V or X	X follow Medicare (title XVIII) for a CAH reimbursed 101% of	N	N	98.
in column 2 for t	es cost? Enter "Y" for yes or "N" for no in column 1 for title V, and tle XIX.			
3.05 Does title V or X	X follow Medicare (title XVIII) and add back the RCE disallowance on	Υ	Y	98
wkst. C, Pt. I, c column 2 for titl	ol. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in e XIX.			
3.06 Does title V or X	X follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	Υ	Y	98
column 2 for titl	PEnter "Y" for yes or "N" for no in column 1 for title V, and in RIX.			
Rural Providers			<u>'</u>	
5.00 Does this hospita 6.00 If this facility	qualify as a CAH? _l ualifies as a CAH, has it elected the all-inclusive method of payment	N N		105 106
for outpatient se	vices? (see instructions)			
	105 is Y, is this facility eligible for cost reimbursement for I&R PENTER "Y" for yes or "N" for no in column 1. (see instructions)	N		107
	umn 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an			
	education program in the CAH's excluded IPF and/or IRF unit(s)? or "N" for no in column 2. (see instructions)			
illiter i for yes	or in tol the column z. (See This tructions)	1	1	I

Health Financial Systems HENDRICKS REGION HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15_0005 Pc	In Lie eriod:	eu of Form CMS- Worksheet S-2	
HOSTITAL AND HOSTITAL HEALTH CARL COMMERN TRENTITION DATA	Trovider C		om 01/01/2021	Part I	
				5/26/2022 12:	
			V 1. 00	XI X 2. 00	+
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	N		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
100 0015 111 1 115	1.00	2.00	3. 00	4.00	100.00
109.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
440 0001 111 1 1 1 1 1 1 1			104	1.00	110.00
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	Y" for yes or	"N" for no. It	f yes,	N	110.00
			1. 00	2. 00	
111.00 f this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting Dumn 1 is Y, ticipating in	period? Enter enter the n column 2.	N		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 ceal participation in the demonstration, if applicable.	peri od? 5 "Y", enter ne	N N	2. 00	0.00	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N		1	_ 0115.00
in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	3, or E only) 3" percent includes				
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 insur	ance? Enter	Y			117. 00
"Y" for yes or "N" for no. 118.00 Is the mal practice insurance a claims-made or occurrence pol	icv? Enter 1	1			118.00
if the policy is claim-made. Enter 2 if the policy is occurr		D			
		Premi ums	Losses	Insurance	
110.00		1.00	2. 00	3.00	0110 01
118.01 List amounts of malpractice premiums and paid losses:		2, 251, 323	(0	0118.01
110 00 4		+ la + la -	1.00	2. 00	110.00
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			1. 00 N	2.00	
Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00D0 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 qualifies the support of the	lule listing of I Harmless pro I column 1, "Y Halifies for 1	cost centers ovision in ACA /" for yes or the Outpatient		2.00 N	119.00
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1001 I TAL AND HOOFI IAL HEALIN CARE COMPLE	X IDENTIFICATION DATA	Provi der CO	CN: 15-0005	Peri od		Worksheet S	S-2552- -2
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					1. 00	2. 00	
80.00 f this is a Medicare certified pa	ancreas transplant center	, enter the cer	ti fi cati on		1.00	2.00	130. (
date in column 1 and termination of this is a Medicare certified in			orti fi cati o	n			131. (
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32.00 If this is a Medicare certified is			ication dat	е			132. (
in column 1 and termination date, 33.00 Removed and reserved	ir applicable, in column	2.					133. (
34.00 If this is an organ procurement of and termination date, if applicable AII Providers		the OPO number	in column 1				134.
40.00 Are there any related organization	n or home office costs as	defined in CMS	Pub. 15-1,		N		140.
chapter 10? Enter "Y" for yes or				ts			
are claimed, enter in column 2 the	e nome office chain number		trons)		3. 00		
If this facility is part of a cha			ough 143 the	name ar	nd address	of the home	
office and enter the home office 41.00Name:	Contractor name and contr	actor number.	Contrac	tor's Nu	ımber:		141. (
42.00 Street:	PO Box:						142. (
43. 00 Ci ty:	State:		Zi p Cod	e:			143.
						1.00	
44.00 Are provider based physicians' co	sts included in Worksheet	A?				Y	144. (
					1. 00	2. 00	
45.00 If costs for renal services are cl					Υ		145.
inpatient services only? Enter "Y' no, does the dialysis facility ind							
period? Enter "Y" for yes or "N"	for no in column 2.						
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	n column 1. (See CMS Pub.			lf	N		146.
lyes, enter the approval date (min/	du/yyyy) 111 corumii 2.						
47.00 Was there a change in the statist	the land of the living Con-					1. 00	
		you or "N" for	no.			l N	1/7
48.00 Was there a change in the order o						N N	147. 148.
	f allocation? Enter "Y" f	or yes or "N" f Enter "Y" for y	or no. es or "N" f		: ±1 - W	N N	148. 149.
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19.00 Was there a change to the simplification. Does this facility contain a prov	f allocation? Enter "Y" for ied cost finding method? I	or yes or "N" fEnter "Y" for y Part A 1.00 n exemption from	res or "N" f Part B 2.00 The appli	cation o	3.00 of the low	N N Title XIX 4.00 er of costs	148. 149.
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Does this facility contain a provor charges? Enter "Y" for yes or 65.00 Hospital 66.00 Subprovider - IPF 67.00 Subprovider - IRF 68.00 SUBPROVIDER 69.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 15 this hospital part of a Multical Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	f allocation? Enter "Y" for ed cost finding method? dider that qualifies for a "N" for no for each compound hospital that has on Name 0	or yes or "N" f Enter "Y" for y Part A 1.00 n exemption froment for Part A N N N N 1 N N 1 N N N N N N N N N N N	For no. Tes or "N" f Part B 2.00 The applia and Part B N N N N N State Z 2.00	ferent C	3.00 of the low l2 CFR §41 N N N N N BSAs?	N N N N N 1 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	148. 149. 155. 156. 157. 158. 159. 160. 161.
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Does this facility contain a provor charges? Enter "Y" for yes or IRF 67.00 Subprovider - IRF 69.00 SUBPROVIDER 69.00 SNF 69.00 SNF 69.00 SNF 69.00 CMHC Multicampus 65.00 Is this hospital part of a Multicate Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 16.00 Is this provider is	ampus hospital that has on Name O T) incentive in the Americal under \$1886(n)? Enter \$25 is "Y") and is a meaning and cost finding method?	or yes or "N" f Enter "Y" for y Part A 1.00 n exemption froment for Part A N N N N N 1 N N N N N N N N N N N N N	For no. Tes or "N" f Part B 2.00 The application of the applicatio	ferent Continue to the continu	3.00 of the low 2 CFR §41 N N N N N BSAS? CBSA 4.00	N N N N N A 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	148. 149. 155. 156. 157. 158. 159. 160. 161.
Does this facility contain a provor charges? Enter "Y" for yes or Subprovider - IRF control of the control of t	ampus hospital that has on Name O T) incentive in the Americal under §1886(n)? Enter solutions a meaning and is a meaning a	or yes or "N" f Enter "Y" for y Part A 1.00 n exemption froment for Part A N N N N N 1 N N N N N N N N N N N N N	Tor no. Tes or "N" f Part B 2.00 The appliant and Part E N N N N N N N N N N N N N N N N N N N	ferent Continue Conti	3.00 of the low 12 CFR §41 N N N N N S BSAs? CBSA 4.00	N N N N N A 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	148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 165. 166.
Does this facility contain a provor charges? Enter "Y" for yes or 65.00 Hospital 66.00 Subprovider - IPF 67.00 Subprovider - IRF 88.00 SUBPROVIDER 69.00 SNF 99.00 SNF 90.00 HOME HEALTH AGENCY 91.00 CMHC Multicampus 95.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no. Modification of the following of the second of the 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) Health Information Technology (HI of 100 is this provider a meaningful user 100 is this provider is a CAH (line 100 is this provider is a CAH	ampus hospital that has on Name O T) incentive in the Americal runder §1886(n)? Enter "Y" for yes or "N" for	representation of the second o	or no. res or "N" f Part B 2.00 The application of the application	ferent C ip Code 3. 00	3.00 of the low 2 CFR §41 N N N N N BSAs? CBSA 4.00	N N N N N A 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	148. 149. 155. 156. 157. 158. 159. 160. 161.

Lieu of Form CMS-2552-10	In Lie	AL HEALTH	HENDRICKS REGION	Heal th Financial		
Worksheet S-2	Peri od:		H CARE COMPLEX IDENTIFICATION DATA	HOSPITAL AND HO		
	From 01/01/2021					
	10 12/31/2021	1				
g Endi ng	Begi nni ng					
2. 00	1. 00					
170.00		170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				
2. 00	1. 00					
0 171. 00	N	viduals enrolled in	loes this provider have any days for indi	171.00 If line 1		
		section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter				
	on	"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section				
			column 2. (see instructions)			
5/26/2022 12: g Endi ng 2. 00	1.00 N	te for the reporting viduals enrolled in , line 2, col. 6? Enter	mm/dd/yyyy) loes this provider have any days for indiction of the cost plans reported on Wkst. S-3, Pt. I for no in column 1. If column 1 is yes, e	period re 171.00 If line 1 section 1 "Y" for y		

Heal th	Financial Systems HENDRICKS REG	IONAL HEALTH		In Lie	u of Form CMS-	2552-10
HOSPI 7	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Period: From 01/01/2021	Worksheet S-2 Part II	2
				o 12/31/2021	Date/Time Pre	
				Y/N	5/26/2022 12: Date	56 pm
	lo 11 1 5 1 1 1 5 1 1 1 1 1 1 1 1 1 1 1 1			1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format.	N for all NO re	esponses. Ente	r all dates in	the	
	COMPLETED BY ALL HOSPITALS					
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	e heainnina of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in		instructions)			1.00
			1. 00	Date 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in the Medicare	Program? If	N N	2.00	3.00	2.00
	yes, enter in column 2 the date of termination and in colu	mn 3, "V" for				
3.00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including management					3.00
	contracts, with individuals or entities (e.g., chain home	offices, drug				
	or medical supply companies) that are related to the proviofficers, medical staff, management personnel, or members					
	of directors through ownership, control, or family and oth					
	relationships? (see instructions)		Y/N	Type	Date	
			1. 00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer	tified Dublic	У	A	05/21/2021	4.00
4.00	Accountant? Column 2: If yes, enter "A" for Audited, "C"		'	A	03/21/2021	4.00
	or "R" for Reviewed. Submit complete copy or enter date av	ailable in				
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diff	erent from	N			5.00
	those on the filed financial statements? If yes, submit re	conciliation.		\/ /NI	1 1 0	
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities					
6. 00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, i:	s the provider	N		6.00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see i			N		7. 00
8. 00	Were nursing programs and/or allied health programs approvious reporting period? If yes, see instructions.	ed and/or rene	wed during the	N		8. 00
9. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
10. 00	program in the current cost report? If yes, see instructio Was an approved Intern and Resident GME program initiated		the current	N		10.00
10.00	cost reporting period? If yes, see instructions.					10.00
11. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N		11.00
	reaching frogram on worksheet A: IT yes, see that detrons.				Y/N	
	Bad Debts				1. 00	
12. 00	Is the provider seeking reimbursement for bad debts? If ye	s, see instruc	tions.		Υ	12.00
13. 00	If line 12 is yes, did the provider's bad debt collection	policy change	during this co	st reporting	N	13.00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paym	ents waived? I	f yes, see ins	tructions.	N	14.00
	Bed Complement				.,	1
15.00	Did total beds available change from the prior cost report		yes, see inst t A		Y t B	15.00
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2. 00	3. 00	4. 00	
16.00	Was the cost report prepared using the PS&R Report only?	Y	03/18/2022	Υ	03/18/2022	16. 00
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17. 00
	either column 1 or 3 is yes, enter the paid-through date					
10.00	in columns 2 and 4. (see instructions)	N		N		10.00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18.00
	but are not included on the PS&R Report used to file this					
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.	I	I	1	I	I

20. 00 If Filine 16 or 17 is yes, were adjustments made to PSSR	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0005	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/26/2022 12:	epared:
20. 00 If films 16 or 17 is, yes, were adjustments made to PS&R N N N 20.0			Descr	iption	Y/N		J
Report data for Other? Describe the other adjustments: Report data for Other? Describe the other adjustments: Y/N Date Y/N Date					1. 00	3. 00	
21.00 Was the cost report prepared only using the provider's N N 21.00 Complete By Cost Periodic Provider	20. 00				N	N	20.00
21.00 Was the cost report prepared only using the provider's N N 21.00							
records? If yes, see instructions. 1.00 COMPLETED BY COST RELIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Olive assets been relifed for Medicare purposes? If yes, see instructions 1.00 2.00 Nove changes occurred in the Medicare depreciation expense due to appraisals made during the cost Nove changes occurred in the Medicare depreciation expense due to appraisals made during the cost Nove changes occurred in the Medicare depreciation expense due to appraisals made during the cost Nove changes occurred in the Medicare depreciation expense due to appraisals made during the cost Nove changes occurred in the Medicare depreciation expense due to appraisals made during the cost Nove changes or control of the medicare depreciation expense due to appraisals made during the cost Nove changes or change change in the cost reporting period? If yes, see Nove changes or capitalization policy changed during the cost reporting period? If yes, see Nove changes or capitalization policy changed during the cost reporting period? If yes, submit Nove copy. Nove changes or capitalization policy changed during the cost reporting period? If yes, submit Nove copy. Nove changes or capitalization policy changed during the cost reporting period? If yes, submit Nove copy. Nove changes or capitalization policy changed during the cost reporting period? If yes, see instructions. Nove the provider have a funded depreciation account and/or band funds (Debt Service Reserve Fund) Nove changes or new control or to its school default you with new debt? If yes, see Nove difference or capitalization control or to its school default you with new debt? If yes, see Nove difference or new agreements occurred in patient care services furnished through contractual Nove changes or new agreements occurred in patient care services furnished through contractual Nove changes or new agreements occurred in patient care services furnished through contractual Nove changes or new agreements occurred in patie				2. 00		4. 00	
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Have assets been relifed for Medicare purposes? If yes, see instructions N 22.0			EL L'OHI EDICEIGO	1001111120)			
Name	22. 00		e instructions			N	22. 00
Were new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.0	23. 00	Have changes occurred in the Medicare depreciation expense			ring the cost	N	23. 00
instructions. 26.00 Wore assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.0 words are period? If yes, see instructions. 28.00 Wore new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28.00 Wore new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.0 treated as a funded depreciation account? If yes, see instructions instructions. 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.0 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.0 instructions. 32.00 Has changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 Has changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If I in 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.0 if yes, see Instructions. 34.00 If yes, see Instructions. 35.00 If I in 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians? N 34.0 if yes, see Instructions. 36.00 Were home office costs claimed on the cost report? 37.00 If I in 36 is yes, has a home office cost statement been prepared by the home office? N 1.00 2.00 38.00 If I in 36 is yes, was the fiscal year end of the home office different from that of the provider? I yes, enter in column 2 the fiscal year end of the home office. 38.00 If I in 36 is yes, did the provider render servic	24. 00		N	24.00			
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 27.00 27.	25. 00		the cost repo	rting period	? If yes, see	N	25. 00
Name	26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost report	ing period?	If yes, see	N	26. 00
28.00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 Treated as a funded depreciation account? If yes, see Instructions N 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 N 10.00 N	27. 00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? I	f yes, submit	N	27. 00
Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions. 30.00	28. 00	Were new Loans, mortgage agreements or Letters of credit en	ntered into du	ring the cos	t reporting	N	28. 00
30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.01 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N and N as envices furnished at the provider facility under an arrangement with provider-based physicians? N and N are services furnished at the provider facility under an arrangement with provider-based physicians? N and N are services furnished at the provider facility under an arrangement with provider-based physicians? N and N are services furnished at the provider facility under an arrangement with provider-based physicians? N and N are services furnished at the provider facility under an arrangement with provider-based physicians? N and N are services for the provider facility under an arrangement with provider-based physicians? N and N are services for facility under an arrangement with provider-based physicians? N and N arrangements with the provider-based physicians? N and N arrangements with the provider-based physicians during the cost reporting period? If yes, see instructions. 32.00 Were home office costs 33.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N and N are services to the home office? N and N are services are services to the home office? If yes, see instructions. 34.00 If line 36 is yes, did the provider render services to other chain components? If yes, N and N are services are nother chain components? If yes, N are see instructions. 35.00 If line 36 is yes, did the provider render services to other chain components? If yes, N are services are nother chain components? If yes, N are services are nother chain components? If yes, N ar	29. 00	Did the provider have a funded depreciation account and/or		ebt Service	Reserve Fund)	N	29. 00
Nas debt been recalled before scheduled maturity without issuance of new debt? If yes, see Natural	30. 00	Has existing debt been replaced prior to its scheduled mate		debt? If ye	s, see	N	30.00
Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.0 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.0 34.00 See instructions.	31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If ye	s, see	N	31.00
33.00 If lime 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If No. 33.0 no. see instructions. Provider-Based Physicians 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? No. 34.0 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based No. 35.0 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based No. 35.0 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based No. 35.0 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based No. 35.0 If line 36 is yes, has a home office cost statement been prepared by the home office? No. 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? No. 37.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. No. 38.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see No. 40.0 Instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO., LLC	32. 00	Have changes or new agreements occurred in patient care se		ed through c	ontractual	N	32.00
34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? 35.00 If yes, see instructions. 36.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 36.00 Physicians during the cost reporting period? If yes, see instructions. Home Office Costs	33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to compet	itive bidding? If	N	33.00
If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.0		Provi der-Based Physi ci ans					
physicians during the cost reporting period? If yes, see instructions. Private Pr		If yes, see instructions.	· ·	•	. ,	N	34.00
Home Office Costs 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office. 40.00 If line 36 is yes, did the provider render services to the home office. 41.00 If line 36 is yes, did the provider render services to the home office. 42.00 If line 36 is yes, did the provider render services to the home office. 42.00 If line 36 is yes, did the provider render services to the home office. 42.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 42.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 42.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 43.00 If line 36 is yes, did the	35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in	isting agreeme nstructions.	nts with the	provi der-based	N	35.00
Home Office Costs 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? ALESSANDRINI 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report BLUE & CO., LLC 42.0							
36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 18.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 38.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO., LLC 42.00 BLUE & CO., LLC					1. 00	2. 00	
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office. ALESSANDRINI 41.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 42.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 3	24 00				N.I		1 2/ 00
If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see N 40.0 instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO., LLC 42.0 preparer.			ropared by the	homo office			
the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 41.00 If line 36 is yes, did the provider render services to other cha		If yes, see instructions.					
see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO., LLC 42.00 preparer.		the provider? If yes, enter in column 2 the fiscal year en	d of the home	offi ce.			
instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report Enter the first name, last name and the title/position Enter the first name, last name and the title/position Enter the first name, last name and the title/position Enter the first name, last name and the title/position Enter the first name, last name and the title/position Enter the first name, last name and the title/position Enter the employer/company name of the cost report Ente		see instructions.	•	,			
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. BLUE & CO., LLC 42.00	40. 00		nome office?	ıı yes, see	N		40.00
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report BLUE & CO., LLC 42.00 preparer.			1	00	2	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, respectively. 41.00 Enter the employer/company name of the cost report preparer. 41.00 BLUE & CO., LLC 42.00		Cost Report Preparer Contact Information					
42.00 Enter the employer/company name of the cost report BLUE & CO., LLC 42.00 preparer.	41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	MI CHAEL		ALESSANDRI NI		41.00
	42. 00	Enter the employer/company name of the cost report	BLUE & CO., LL	.C			42.00
	43. 00	· ·	317. 713. 7959		MALESSANDRI NI @	BLUEANDCO. COM	43.00

Heal th Finar	ncial Systems	HENDRICKS REGI	ONAL HEALTH		In Lieu of Form CMS-2552-10				
HOSPITAL AN	D HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-0005	Peri From To	od: 01/01/2021 12/31/2021		pared:	
				3. 00	-				
Cost	Report Preparer Contact Information								
	r the first name, last name and the		OI RECTOR					41.00	
	by the cost report preparer in colum	mns 1, 2, and 3,							
	ecti vel y.								
42. 00 Enter	r the employer/company name of the co	ost report						42.00	
prepa									
	r the telephone number and email add							43.00	
repor	rt preparer in columns 1 and 2, respo	ecti vel y.						ļ	

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To | 12/31/2021 | Date/Time Prepared: Provi der CCN: 15-0005

						То	12/31/2021	Date/Time P 5/26/2022 1		
								I/P Days /		о ріп
								0/P Visits		
								Tri ps		
	Component	Worksheet A	No	. of Beds	Bed Days		CAH Hours	Title V		
		Line Number			Avai I abl e					
	I	1. 00		2.00	3. 00		4. 00	5. 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		116	42, 34	.0	0. 00		0	1.00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days) (see instructions for col. 2									
2. 00	for the portion of LDP room available beds)									2. 00
2. 00 3. 00	HMO and other (see instructions)									3.00
4. 00	HMO IPF Subprovider HMO IRF Subprovider									4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF								o	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF								ö	6. 00
7. 00	Total Adults and Peds. (exclude observation			116	42, 34		0. 00		0	7. 00
7.00	beds) (see instructions)			110	42, 34	.0	0.00		۷	7.00
8. 00	INTENSIVE CARE UNIT	31.00		14	5, 11	0	0. 00		0	8. 00
9. 00	CORONARY CARE UNIT	01.00]		0.00		Ĭ	9. 00
10.00	BURN INTENSIVE CARE UNIT									10.00
11. 00	SURGICAL INTENSIVE CARE UNIT									11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)									12.00
13. 00	NURSERY	43.00							ol	13.00
14. 00	Total (see instructions)			130	47, 45	0	0. 00		0	14.00
15.00	CAH vi si ts								0	15.00
16.00	SUBPROVIDER - IPF									16.00
17.00	SUBPROVIDER - IRF									17.00
18.00	SUBPROVI DER									18.00
19.00	SKILLED NURSING FACILITY	44. 00		0		0			0	19.00
20.00	NURSING FACILITY									20.00
21.00	OTHER LONG TERM CARE									21.00
22.00	HOME HEALTH AGENCY									22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)									23.00
24.00	HOSPI CE									24.00
24. 10	HOSPICE (non-distinct part)	30.00								24. 10
25.00	CMHC - CMHC									25.00
26.00	RURAL HEALTH CLINIC									26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00							0	26. 25
27. 00	Total (sum of lines 14-26)			130	1					27. 00
28. 00	Observation Bed Days								0	28.00
29. 00	Ambul ance Tri ps									29. 00
30.00	Employee discount days (see instruction)									30.00
31.00	Employee discount days - IRF									31.00
32.00	Labor & delivery days (see instructions)			0	1	0				32.00
32. 01	Total ancillary labor & delivery room									32. 01
22 00	outpatient days (see instructions)									22 00
	LTCH non-covered days									33. 00 33. 01
33.01	LTCH site neutral days and discharges		l		I	ı	l	I	I	33.01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0005

				T	o 12/31/2021	Date/Time Pre 5/26/2022 12:	
		I/P Days	/ O/P Visits	/ Trips	Full Time F	Equi val ents	об рііі
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
1 00		6. 00	7. 00	8.00	9. 00	10. 00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	5, 648	671	17, 252			1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	2, 622	3, 570				2. 00
3. 00	HMO IPF Subprovider	2,022	3, 570				3.00
4. 00	HMO IRF Subprovider	0	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	O O	0				6.00
7. 00	Total Adults and Peds. (exclude observation	5, 648	671	17, 252			7.00
7.00	beds) (see instructions)	3, 040	071	17, 232			7.00
8. 00	INTENSIVE CARE UNIT	1, 001	0	3, 288			8. 00
9. 00	CORONARY CARE UNIT	1,001	Ü	0, 200			9.00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		0	2, 431			13.00
14. 00	Total (see instructions)	6, 649	671	22, 971	0. 00	1, 743. 46	
15. 00	CAH visits	0	0	0		.,	15.00
16. 00	SUBPROVIDER - IPF		_	_			16.00
17. 00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	O	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			80			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0. 00		
27.00	Total (sum of lines 14-26)				0. 00	1, 743. 46	
28. 00	Observation Bed Days		292	3, 992			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			. 0			31.00
32.00	Labor & delivery days (see instructions)	0	245	565			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
00.00	outpatient days (see instructions)						00.00
33.00	LTCH non-covered days	0					33.00
33. UI	LTCH site neutral days and discharges	0		I		I	33. 01

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To | 12/31/2021 | Date/Time Prepared: Provi der CCN: 15-0005

				To	12/31/2021	Date/Time Pre 5/26/2022 12:	
		Full Time		Di sch	arges	0, 20, 2022 121	<u>оо р</u>
		Equi val ents		1			
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 620	124	5, 374	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)			500	0.40		
2.00	HMO and other (see instructions)			538	842		2.00
3.00	HMO I PF Subprovi der				0		3.00
4. 00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0 00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00	0	1 (20	104	F 274	13.00
14.00	Total (see instructions)	0. 00	0	1, 620	124	5, 374	14.00
15.00	CAH visits						15.00
16. 00 17. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF						16. 00 17. 00
18.00	SUBPROVI DER						17.00
19.00	SKILLED NURSING FACILITY	0.00					19. 00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE			•			21.00
22. 00	HOME HEALTH AGENCY			•			22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)			•			23.00
24. 00	HOSPI CE			•			24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC	•					25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
52. 01	outpatient days (see instructions)						52.01
33.00	LTCH non-covered days			0			33.00
	LTCH site neutral days and discharges			0			33. 01
				•			

	FINANCIAL SYSTEMS		HENDRICKS REGI		ON 45 0005 D		u or Form CMS-2	
HOSPI I	AL WAGE INDEX INFORMATION			Provider C		eriod: rom 01/01/2021 o 12/31/2021	Worksheet S-3 Part II Date/Time Pre 5/26/2022 12:	pared:
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1. 00	Total salaries (see	200.00	174, 395, 140	0	174, 395, 140	3, 626, 387. 31	48. 09	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		0	o	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		1, 068, 974	o	1, 068, 974	8, 202. 00	130. 33	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 17, 241, 534	0	0 17, 241, 534	0. 00 108, 654. 00	0. 00 158. 68	
6. 00	Physician-Part B Non-physician-Part B for		0	O	0	0. 00	0. 00	6. 00
7. 00	hospi tal -based RHC and FQHC services	21. 00	0		0	0.00	0.00	7 00
7. 00	Interns & residents (in an approved program) Contracted interns and	21.00	0			0. 00 0. 00	0. 00 0. 00	
,, ,,	residents (in an approved programs)		Ç			0.00	3. 33	7.0.
8. 00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44. 00	0 61, 234, 935	-94, 846	61, 140, 089	0. 00 1, 016, 934. 48	0. 00 60. 12	9. 00 10. 00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		4, 397, 407	0	4, 397, 407	37, 119. 01	118. 47	11. 00
12. 00	Contract Labor: Top Level management and other management and administrative		0	О	0	0. 00	0. 00	12.00
13. 00	services Contract Labor: Physician-Part A - Administrative		230, 259	О	230, 259	1, 265. 00	182. 02	13. 00
14. 00	Home office and/or related organization salaries and		0	O	0	0. 00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		0		0	0. 00	0.00	14. 01
14. 01			0	0	0	0.00		14.01
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00		15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	O	0	0. 00	0. 00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	o	0	0. 00	0. 00	16. 01
16. 02	Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see instructions)		21, 662, 311	0	21, 662, 311			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		10, 970, 710 0	0	10, 970, 710 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part B		0	О	0			21. 00
22. 00	Physician Part A - Administrative		144, 019	О	144, 019			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0 2, 201, 938	0	0 2, 201, 938			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		0	0	0			25. 50
25. 51	(core) Related organization		0	o	О			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	o	О			25. 52
	wage-related (core)							

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0005 Peri od: Worksheet S-3 From 01/01/2021 Part II Date/Time Prepared: 12/31/2021 5/26/2022 12:56 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of (col. 2 ± col. Sal ari es Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 25. 53 0 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 2, 776, 827 71, 405 2, 848, 232 81, 043. 74 35. 14 26.00 27.00 Administrative & General 5.00 15, 518, 583 177, 652 15, 696, 235 307, 050. 16 51. 12 27.00 28. 00 2, 324, 866 2, 324, 866 7, 064. 80 329. 08 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 2, 812, 115 -1, 170 2, 810, 945 97, 703. 85 28.77 30.00 Laundry & Linen Service 8.00 351, 416 351, 270 19, 154, 13 18. 34 31.00 31.00 -146 146, 983. 82 32.00 Housekeepi ng 9.00 2, 988, 187 -1, 243 2, 986, 944 20. 32 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 2, 021, 522 34.00 Dietary 10.00 -1, 428, 250 593, 272 27, 036. 11 21. 94 34.00 35.00 Dietary under contract (see 13, 638 13, 638 542. 40 25. 14 35.00 instructions) 36.00 Cafeteri a 11.00 1, 427, 409 1, 427, 409 65, 049. 00 21. 94 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 0 97, 094. 53 Nursing Administration 13.00 4, 973, 939 4, 971, 869 51. 21 38.00 38.00 -2,070 39.00 Central Services and Supply 14.00 1, 150, 005 -478 1, 149, 527 46, 647. 05 24.64 39.00 2, 774, 730 2, 773, 576 62, 550. 05 40.00 Pharmacy 15.00 -1, 154 44. 34 40.00 Medical Records & Medical Records Library 501, 635 41.00 16.00 -209 501, 426 19, 356. 47 25. 90 41. 00 42.00 Social Service 17.00 1, 988, 213 -827 1, 987, 386 50, 681. 84 39. 21 42. 00 43.00 Other General Service 18.00 0.00 0.00 43.00

Не	ealth Financial Systems		HENDRICKS REG	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
Н	OSPITAL WAGE INDEX INFORMATION			Provi der Co	CN: 15-0005	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part III Date/Time Pre 5/26/2022 12:	pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	

Net salaries (see instructions) 1.00 2.00 159, 492, 110 3, 525, 340. 51 45. 24 1.00 1.00 2.00 2.30 3.00
Sal ari es (from Worksheet A-6) 1.00 2.00 3.00 4.00 5.00 6.00
Col. 4 Col. 5 Worksheet A-6 A-6
Worksheet A-6) 1.00 2.00 3.00 4.00 5.00 6.00
A-6
The first contains of the first contains o
PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see instructions) 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 98, 257, 175 94, 846 98, 352, 021 2, 508, 406. 03 39. 21 3. 00
1.00 Net salaries (see instructions) 159, 492, 110 0 159, 492, 110 3, 525, 340. 51 45. 24 1.00 2.00 Excluded area salaries (see instructions) 61, 234, 935 -94, 846 61, 140, 089 1, 016, 934. 48 60. 12 2.00 3.00 Subtotal salaries (line 1 minus line 2) 98, 257, 175 94, 846 98, 352, 021 2, 508, 406. 03 39. 21 3.00
instructions) 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 minus line 2) 61,234,935 -94,846 61,140,089 1,016,934.48 60.12 2.00 98,257,175 94,846 98,352,021 2,508,406.03 39.21 3.00
2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 minus line 2) 61, 234, 935 -94, 846 61, 140, 089 1, 016, 934. 48 60. 12 2.00 98, 257, 175 94, 846 98, 352, 021 2, 508, 406. 03 39. 21 3. 00
instructions) 3.00 Subtotal salaries (line 1
3.00 Subtotal salaries (line 1 98, 257, 175 94, 846 98, 352, 021 2, 508, 406. 03 39. 21 3. 00 minus line 2)
minus line 2)
4 00 Subtotal other wages & related 4 627 666 0 4 627 666 38 384 01 120 56 4 00
costs (see inst.)
5.00 Subtotal wage-related costs 21,806,330 0 21,806,330 0.00 22.17 5.00
(see inst.)
6.00 Total (sum of lines 3 thru 5) 124,691,171 94,846 124,786,017 2,546,790.04 49.00 6.00
7.00 Total overhead cost (see 40, 195, 676 240, 919 40, 436, 595 1, 027, 957. 95 39. 34 7. 00
instructions)

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0005	Peri od: Worksheet S-3
		From 01/01/2021 Part IV
		To 12/21/2021 Data/Time Propared

	To 12/31/202	1 Date/Time Pre 5/26/2022 12:	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS	•	
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	5, 139, 256	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	220, 994	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	•	
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8. 00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	15, 848, 986	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	1, 309, 154	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	153, 616	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
	Disability Insurance (If employee is owner or beneficiary)	387, 684	13.00
	Long-Term Care Insurance (If employee is owner or beneficiary)	39, 213	14.00
15.00		760, 265	15.00
16.00	'	0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	10, 787, 370	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
	Unempl oyment Insurance	95, 806	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	ee O	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22.00
	Tuition Reimbursement	236, 633	
	Total Wage Related cost (Sum of Lines 1 -23)	34, 978, 977	1
	Part B - Other than Core Related Cost		1
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2 HOSPITAL CONTRACT LABOR AND BENEFIT COST Provider CCN: 15-0005 Period: From 01/01/2021 To 12/31/2021 Date/Time Pre	
5/26/2022 12:	
Cost Center Description Contract Benefit Cost	
Labor 1.00 2.00	
PART V - Contract Labor and Benefit Cost	
Hospital and Hospital-Based Component Identification:	
1.00 Total facility's contract labor and benefit cost 2,891,547 34,978,977	1.00
2. 00 Hospi tal 2, 891, 547 34, 978, 977	2.00
3.00 Subprovi der - IPF	3.00
4.00 Subprovi der - I RF	4.00
5.00 Subprovi der - (0ther) 0 0	5.00
6.00 Swi ng Beds - SNF 0 0	6.00
7.00 Swi ng Beds - NF 0 0	7.00
8.00 Hospi tal -Based SNF 0 0	8.00
9.00 Hospi tal -Based NF	9.00
10.00 Hospi tal -Based OLTC	10.00
11.00 Hospi tal -Based HHA	11.00
12.00 Separately Certified ASC	12.00
13. 00 Hospi tal -Based Hospi ce	13.00
14.00 Hospital-Based Health Clinic RHC	14.00
15.00 Hospital-Based Health Clinic FQHC	15.00
16.00 Hospi tal -Based-CMHC	16.00
17.00 Renal Dialysis 0 0 0	17.00
18.00 Other 0 0	18.00

	Financial Systems HENDRICKS REGIONAL L UNCOMPENSATED AND INDIGENT CARE DATA F	rovider CCN: 15-00		eri od:	Worksheet S-1	0
			F	rom 01/01/2021		
			T	o 12/31/2021	Date/Time Pre 5/26/2022 12:	
					1. 00	
U	Incompensated and indigent care cost computation				1.00	
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by line 202 o	col umn	8)	0. 243003	1 1.
	ledicaid (see instructions for each line)			,		
00 [1	Net revenue from Medicaid				3, 917, 417	2.
	Did you receive DSH or supplemental payments from Medicaid?				Υ	3
	fline 3 is yes, does line 2 include all DSH and/or supplement		Medi cai	d?	N	4
	fline 4 is no, then enter DSH and/or supplemental payments fr	om Medicaid			3, 755, 582	
	Medicaid charges Medicaid cost (line 1 times line 6)				90, 711, 533	
	Difference between net revenue and costs for Medicaid program (ling 7 minus sum d	of line	as 2 and 5: if	22, 043, 175 14, 370, 176	
	error then enter zero)	Title / IIITius suiii (JI 11110	53 2 and 5, 11	14, 370, 170	
C	children's Health Insurance Program (CHIP) (see instructions fo	r each line)				
	Net revenue from stand-alone CHIP				0	
	Stand-allone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10)		- 0 ! :	6	0	1
	Difference between net revenue and costs for stand-alone CHIP (enter zero)	line ii minus iine	e 9; II	< zero tnen	0	12
	otter state or local government indigent care program (see inst	ructions for each	Line)			1
	Net revenue from state or local indigent care program (Not incl)	0	13
	Charges for patients covered under state or local indigent care				0	14
	10)					
	State or local indigent care program cost (line 1 times line 14				0	
	Difference between net revenue and costs for state or local ind	igent care program	n (line	e 15 minus line	0	16
C	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI	D and state/local	i ndi a	ont caro progra	ume (eoo	ł
	nstructions for each line)	r and State/Tocal	i nui ge	ent care progra	iiis (see	
	Private grants, donations, or endowment income restricted to fu				0	
	Government grants, appropriations or transfers for support of h				0	
	Total unreimbursed cost for Medicaid , CHIP and state and local 3, 12 and 16)	indigent care pro	ograms	(sum of lines	14, 370, 176	19.
	5, 12 did 10)	Uni nsu	ured	Insured	Total (col. 1	
		pati e		pati ents	+ col . 2)	
10	Incomponented Care (see instructions for each line)	1.0	0	2. 00	3. 00	
	Incompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac	ility 10.7	36, 220	2, 697, 518	13, 433, 738	20
	(see instructions)	11111	00, 220	2,077,010	10, 100, 700	20
. 00	Cost of patients approved for charity care and uninsured discou	nts (see 2, 6	08, 934	2, 697, 518	5, 306, 452	21
i	nstructions)					
	Payments received from patients for amounts previously written	off as	0	0	0	22.
1	charity care Cost of charity care (line 21 minus line 22)	2.4	00 024	2, 697, 518	E 204 4E2	22
. 00 [0	cost of charity care (fille 21 millius fille 22)	2,0	08, 934	2,097,310	5, 306, 452	23
					1. 00	
	Does the amount on line 20 column 2, include charges for patien		ength o	of stay limit	N	24
	mposed on patients covered by Medicaid or other indigent care					
	fline 24 is yes, enter the charges for patient days beyond the	e indigent care pr	ogram'	s rength of	0	25.
1	stay limit Fotal bad debt expense for the entire hospital complex (see ins	tructions)			16, 878, 241	26
	Medicare reimbursable bad debts for the entire hospital complex	,	5)		163, 447	1
	Medicare allowable bad debts for the entire hospital complex (s	•	-,		251, 457	
	Non-Medicare bad debt expense (see instructions)				16, 626, 784	
. 00 1						
	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instruct	tions)		4, 128, 368	27
9. 00 (Cost of non-Medicare and non-reimbursable Medicare bad debt exp Cost of uncompensated care (line 23 column 3 plus line 29)	ense (see instruct	ti ons)		9, 434, 820 23, 804, 996	30.

Heal th	Financial Systems	HENDRICKS REGIO	NAL HEALTH		In Lieu	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO	F	Period: From 01/01/2021 To 12/31/2021	Worksheet A Date/Time Pre 5/26/2022 12:	
	Cost Center Description	Sal ari es	0ther	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1. 00	2.00	3. 00	4.00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	0.77/ 007	24, 721, 269			28, 565, 770	1.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	2, 776, 827 15, 518, 583	24, 662, 640 44, 515, 415			27, 378, 810 56, 356, 620	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	2, 812, 115	10, 437, 348			13, 315, 605	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	351, 416	-243, 285			36, 877	8.00
9. 00	00900 HOUSEKEEPI NG	2, 988, 187	957, 957	3, 946, 144	-102, 158	3, 843, 986	9. 00
10.00	01000 DI ETARY	2, 021, 522	1, 533, 111	3, 554, 633		1, 028, 966	10.00
11.00	01100 CAFETERI A	4 072 020	0 544 414	7 510 551	_, _, _, _,	2, 510, 399	11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	4, 973, 939 1, 150, 005	2, 544, 616 1, 607, 334	7, 518, 555 2, 757, 339		7, 068, 533 1, 639, 062	13. 00 14. 00
	01500 PHARMACY	2, 774, 730	27, 472, 595			3, 747, 029	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	501, 635	824, 249			1, 325, 675	•
17. 00	01700 SOCIAL SERVICE	1, 988, 213	233, 400	2, 221, 613		2, 224, 493	
23. 00	02300 PARAMED ED PRGM-EMS	0	0	(193, 898	193, 898	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	19, 421, 603	3, 565, 698	22, 987, 30	-5, 890, 005	17, 097, 296	30.00
31. 00	03100 INTENSIVE CARE UNIT	2, 878, 631	1, 507, 395			3, 788, 895	31.00
	04300 NURSERY	0	0	(1, 778, 431	
44.00	04400 SKILLED NURSING FACILITY	0	0	(0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50. 00 50. 01	05000 OPERATING ROOM 05001 ENDOSCOPY	2, 776, 779	13, 850, 214			15, 993, 520	50.00
50.01	05100 RECOVERY ROOM	1, 120, 100 1, 681, 818	708, 201 395, 203	1, 828, 30° 2, 077, 02°		1, 272, 781 1, 847, 295	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	37, 321	37, 32		3, 201, 576	52.00
53.00	05300 ANESTHESI OLOGY	7, 463, 031	953, 694			8, 151, 054	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 550, 453	2, 954, 362			8, 460, 141	54.00
54. 01	05401 RADI ATI ON-ONCOLOGY	892, 623	1, 532, 261		1	2, 495, 709	54.01
56. 00 56. 01	05600 RADI OI SOTOPE 05601 NUCLEAR MEDI CI NE	0 280, 835	0 332, 578	613, 413	1 1	0 571, 313	56. 00 56. 01
59. 00	05900 CARDI AC CATHETERI ZATI ON	668, 534	2, 348, 543			972, 739	59.00
60.00	06000 LABORATORY	3, 699, 287	7, 428, 131	11, 127, 418		10, 709, 747	60.00
64.00	06400 INTRAVENOUS THERAPY	1, 469, 220	281, 998	1, 751, 218	-276, 274	1, 474, 944	64.00
65. 00	06500 RESPI RATORY THERAPY	2, 675, 843	1, 489, 801	4, 165, 644		3, 881, 725	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	6, 908, 579	1, 970, 078			8, 616, 402	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	542, 969 355, 133	52, 570 34, 347			615, 072 386, 842	1
69. 00	06900 ELECTROCARDI OLOGY	991, 552	548, 707			1, 324, 364	•
69. 01	06901 CARDI AC REHAB	724, 618	78, 350			789, 848	1
70.00	07000 ELECTROENCEPHALOGRAPHY	90, 775	12, 832		1	98, 294	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(1	10,000,001	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0		10, 998, 901 27, 345, 652	10, 998, 901 27, 345, 652	
	07301 ULTRA SOUND	585, 852	81, 026			632, 716	
74.00	07400 RENAL DIALYSIS	308	479, 072	479, 380		479, 380	74.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	1, 577, 348	4, 019, 694			4, 737, 752	90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 947, 142	2, 598, 119	14, 545, 26	-903, 403	13, 641, 858	91.00 92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	113, 160, 205	186, 526, 844	299, 687, 049	912, 921	300, 599, 970	118. 00
	19200 PHYSICIANS' PRIVATE OFFICES	52, 122, 158	20, 612, 540			71, 831, 605	1
	19201 HEALTH TRACKS	3, 374, 495	886, 986			4, 260, 077	
	07950 PRIMARY CARE CLINIC 07951 PARTNERS IN CARE	1, 444, 164 0	1, 181, 586 3, 451	2, 625, 750 3, 45°		2, 625, 149 3 <i>4</i> 51	194.00
	07951 PARTNERS IN CARE 07952 OCCUPATIONAL MEDICINE	531, 735	563, 934	1, 095, 669		1, 095, 448	
	07953 FOUNDATI ON	120, 036	14, 128			134, 114	
	07954 SCHOOL & TOWN CLINICS	1, 937, 236	887, 429	2, 824, 665		2, 817, 823	
	07955 MANAGED FACILITY	427, 101	197, 528			624, 451	
	07956 RENTAL PROPERTIES 07957 SNF NON CERTIFIED	0 1, 278, 010	99, 154 265, 697	99, 154 1, 543, 707		99, 154 1, 543, 175	
200.00	i i	174, 395, 140	203, 097			385, 634, 417	
	(., 5.5,	, == , , = , ,		, 9		

Peri od: Worksheet A From 01/01/2021 Date/Time Prepared: 5/26/2022 12:56 pm

Cost Center Description
GENERAL SERVICE COST CENTERS
SENERAL SERVICE COST CENTERS 1.00 7.00 1.00
CENTRAL SERVICE COST CENTRES
1.00
4. 00
5.00
7. 00 00700 00700 00FPAINT 0.79, 967 13, 235, 638 7. 00 9. 00 00900 LAUNDRY & LINEN SERVI CE -211 36, 666 8. 00 9. 00 00900 HOUSEKEEPI NG 1, 032 3, 842, 954 9. 00 11. 00 01100 01100 02FETERI A 9. 07, 757 1, 572, 826 11. 00 11. 00 01100 02FETERI A 9. 07, 753, 587 13. 00 11. 00 01100 02FETERI A 9. 07, 753, 587 13. 00 11. 00 01400 NURSI NG ADMINI STRATION -14, 946 7, 63, 587 13. 00 11. 00 01400 NURSI NG ADMINI STRATION -14, 946 7, 635, 587 13. 00 11. 00 01400 NEDICAL RECORDS & LIBRARY -945 1, 324, 730 16. 00 110. 00 01700 SOCIAL SERVI CES & SUPPLY -4, 517 1, 634, 545 14. 00 110. 00 01700 SOCIAL SERVI CES & -353 2, 224, 140 17. 00 110. 00 01700 SOCIAL SERVI CES & -4, 448, 566 15. 00 110. 00 01700 SOCIAL SERVI CE SOST CENTERS -4, 448, 566 12, 648, 730 31. 00 31. 00 03000 ADULTS & PEDI ATRIC S -4, 448, 566 12, 648, 730 31. 00 31. 00 03000 NURSERY 0 0 778, 431 43. 00 31. 00 03000 NURSERY 0 0 778, 431 43. 00 31. 00 04000 SKILLED NURSI NG FACILITY 0 0 0 31. 00 05000 DEED SERVI CE COST CENTERS -4, 448, 566 12, 648, 730 31. 00 31. 00 05000 DEED SERVI CE COST CENTERS -4, 448, 566 12, 648, 730 31. 00 31. 00 05000 DEED SERVI CE COST CENTERS -4, 448, 566 12, 648, 730 31. 00 31. 00 03000 NURSERY 0 0 778, 431 43. 00 31. 00 03000 NURSERY 0 0 778, 431 43. 00 31. 00 03000 NURSERY 0 0 0 0 31. 00 05000 DEED SERVI CE COST CENTERS -4, 448, 566 12, 648, 730 31. 00 31. 00 05000 DEED SERVI NG ROM -976 15, 992, 544 50. 00 31. 00 05000 DEED SERVI NG ROM -976 15, 992, 544 50. 00 31. 00 05000 DEED SERVI NG ROM -976 15, 992, 544 50. 00 31. 00 05000 DEED SERVI NG ROM -976 15, 992, 544 50. 00 31. 00 05000 DEED SERVI NG ROM -976 15, 992, 544 50. 00 31. 00 05000 DEED SERVI NG ROM -976 15, 992, 5
8. 00 00800 LAUNDRY & LINEN SERVICE
9.00 09900 HOUSEKEEPING
10.0 010000 010000 010000 010000 010000 0100000 0100000 0100000 0100000 0100000 0100000 0100000 01000000 010000000 010000000 010000000 010000000 010000000 0100000000
11.00 01100 CAETERIA .937,573 1,572,826 11.00 10300 NURSIN GADMIN ISTRATION .14,946 .7,053,587 .13,00 .10300 NURSIN GADMIN ISTRATION .14,946 .7,053,587 .13,00 .10300 NURSIN GADMIN ISTRATION .14,946 .14,00 .16,00
13.00 01300 NURSIN SIN STRATION
14. 00 01400 CENTRAL SERVICES & SUPPLY -4, 517 1, 634, 545 1, 500 16500 PARAMECY -37, 709 3, 709, 320 15. 00 16500 PARAMECY -945 1, 324, 730 16. 00 17. 00 01700 SOCI AL SERVICE -33, 353 2, 224, 140 17. 00 17. 00 20300 PARAMED ED PROM-EMS -41, 941 151, 957 23. 00 20300 PARAMED ED PROM-EMS -41, 941 151, 957 23. 00 20300 PARAMED ED PROM-EMS -41, 941 151, 957 23. 00 20300 ADURTS & PEDIATRIC SERVICE COST CENTERS -41, 941 151, 957 23. 00 20300 ADURTS & PEDIATRIC SERVICE COST CENTERS -41, 941 151, 957 23. 00 20300 ADURTS & PEDIATRIC SERVICE COST CENTERS -41, 941 151, 957 23. 00 20300 AUSTRA & PEDIATRIC SERVICE COST CENTERS -41, 941 151, 957 23. 00 20300 AUSTRA & PEDIATRIC SERVICE COST CENTERS -41, 941 151, 941 243, 00 240, 240 244, 00
15. 00 01500 PARMINCY -37, 709 3, 709, 320 15. 00 16. 00 01600 MEDICAL RECORDS & LI BRARY -945 1, 324, 730 16. 00 17. 00 0700 SOCI AL SERVI CE -353 2, 224, 140 17. 00 23. 00 02300 PARAMED ED PROM-EMS -41, 941 151, 957 23. 00 18. 00 03000 ADULTS & PEDIATRI CS -44, 448, 566 12, 648, 730 30. 00 31. 00 03100 INTENSI YE CARE UNI T -186, 013 3, 602, 882 31. 00 44. 00 04400 SKI LLED NURSI NG FACI LLI TY 0 0 0 0 44. 00 04400 SKI LLED NURSI NG FACI LLI TY 0 0 0 0 44. 00 04400 SKI LLED NURSI NG FACI LLI TY 0 0 0 0 44. 00 04400 SKI LLED NURSI NG FACI LLI TY 0 0 0 0 45. 00 05000 DEPRATI NG ROOM -390 1, 846, 905 51. 00 50. 01 05000 DEPRATI NG ROOM -390 1, 846, 905 51. 00 51. 00 05000 DELINOSCOPY -166 1, 272, 615 50. 00 52. 00 05200 DELIVERY ROOM -390 1, 846, 905 51. 00 53. 00 05300 ARISTHESI OLOGY -8, 353, 292 -202, 238 53. 00 54. 01 05400 RADIO ALOR PLA INCOLOGY -500 2, 495, 209 54. 00 54. 01 05400 RADIO LOO-PLI AGNOSTI C -123, 354 8, 336, 787 54. 00 55. 01 05600 RADIO INSTORE -247 571, 066 56. 00 55. 01 05600 RADIO INSTORE -247 571, 066 56. 00 55. 01 05600 ARDIO LOOTOPE -247 571, 066 56. 00 55. 01 05600 ARDIO LOOTOPE -247 571, 066 56. 00 56. 00 05600 CARDIATORY -3836, 331 10, 373, 416 60. 00 66. 00 06600 PAYSI CAL THERAPY -74, 401 1, 460, 543 66. 00 06600 PAYSI CAL THERAPY -784, 180 7, 832, 222 66. 00 06600 ASDORATORY -784, 180 7, 832, 222 66. 00 06600 ASDORATORY -784, 180 7, 832, 222 67. 00 07000 CLECTROCARDIO LOGY -186, 639 1, 137, 725 68. 00 06600 SPECH PATHOLOGY -244, 107 -784, 180 7, 832, 222 69. 00 06900 LARORATORY -186, 639 1, 137, 725 69. 00 07000 07000 07000 07000 07000 70. 00 07000 07000 07000 07000 07000 71. 00 07000 07000
16. 00
17.00 01700 SOCI AL SERVI CE -353 2, 224, 140 17.00 23.00 23.00 20.00 20.00 22.00 20
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS -4, 448, 566 12, 648, 730 33.00 33.00 30.00 30.00 INTENSI VE CARE UNIT -186, 013 3, 602, 882 31.00 31.00 30.00 30.00 INTENSI VE CARE UNIT -186, 013 3, 602, 882 31.00 31.00 30.0
30. 00
31.00 03100 NTENSI VE CARE UNI T
43.00 04300 NURSERY 0 1,778,431 44.00 0 0 0 0 0 0 0 0 0
44. 00
ANCI LLARY SERVI CE COST CENTERS
50. 00 05000 OPERATI ING ROOM -976 15, 992, 544 50. 00 50. 00 ENDOSCOPY -166 1, 272, 615 50. 00 50. 00 ENDOSCOPY -166 1, 272, 615 50. 00 50. 00 ENDOSCOPY -166 1, 272, 615 50. 00 50. 00 ELI VERY ROOM & LABOR ROOM 0 3, 201, 576 52. 00 50. 00 50. 00 ANESTHESI OLOCY -8, 353, 292 -202, 238 53. 00 50. 00 50. 00 ANESTHESI OLOCY -8, 353, 292 -202, 238 53. 00 50. 00 50. 00 ANESTHESI OLOCY -123, 354 8, 336, 787 54. 00 54. 00 54. 00 54. 00 54. 00 54. 00 54. 00 54. 00 54. 00 56. 0
50. 01 05001 ENDOSCOPY
51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 3, 201, 576 52. 00 53. 00 05300 ANESTHESI OLOGY -8, 353, 292 -202, 238 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C -123, 354 8, 336, 787 54. 00 05401 RADI ATI ON-ONCOLOGY -500 2, 495, 209 54. 00 56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 0
53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C -123, 354 8, 336, 787 54. 00 54. 01 05401 RADI ATI ON-ONCOLOGY -500 2, 495, 209 54. 0° 56. 00 05600 RADI OI SOTOPE 0 0 56. 0° 56. 01 05601 NUCLEAR MEDI CI NE -247 571, 066 56. 0° 59. 00 05900 CARDI AC CATHETERI ZATI ON -294 972, 445 59. 0° 60. 00 06000 LABORATORY -336, 331 10, 373, 416 60. 0° 64. 00 06400 INTRAVENOUS THERAPY -14, 401 1, 460, 543 65. 0° 65. 00 06500 RESPI RATORY THERAPY -779 3, 880, 946 65. 0° 66. 00 06600 PHYSI CAL THERAPY -784, 180 7, 832, 222 66. 0° 67. 00 06700 OCCUPATI ONAL THERAPY -48, 107 566, 965 67. 0° 68. 00 06800 SPEECH PATHOLOGY -22 386, 820 69. 0° 69. 01 06901 CARDI AC REHAB -172 789, 676 69. 0° 70. 00 07000 ELECTROCARDI OLOGY -186, 639 1, 137, 725 69. 0° 69. 01 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 71. 00 07100 OTOOL IMPL. DEV. CHARGED TO PATI ENTS 0 27, 345, 652
54. 01
56. 00
56. 01 05601 NUCLEAR MEDICINE -247 571, 066 56. 07 59. 00 05900 CARDIAC CATHETERIZATION -294 972, 445 59. 00 60. 00 06000 LABORATORY -336, 331 10, 373, 416 60. 00 64. 00 06400 INTRAVENOUS THERAPY -14, 401 1, 460, 543 64. 00 65. 00 06500 RESPI RATORY THERAPY -779 3, 880, 946 65. 00 66. 00 06600 PHYSI CAL THERAPY -784, 180 7, 832, 222 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY -48, 107 566, 965 67. 00 68. 00 06800 SPEECH PATHOLOGY -22 386, 820 68. 00 69. 01 06900 ELECTROCARDI OLOGY -186, 639 1, 137, 725 69. 00 69. 01 06901 CARDIAC REHAB -172 789, 676 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY -70 98, 224 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 73. 01 07300
59. 00 05900 CARDI AC CATHETERI ZATI ON -294 972, 445 59. 00 60. 00 06000 LABORATORY -336, 331 10, 373, 416 60. 00 64. 00 06400 INTRAVENOUS THERAPY -14, 401 1, 460, 543 64. 00 65. 00 06500 RESPI RATORY THERAPY -779 3, 880, 946 65. 00 66. 00 06600 PHYSI CAL THERAPY -784, 180 7, 832, 222 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY -48, 107 566, 965 67. 00 68. 00 08800 SPEECH PATHOLOGY -22 386, 820 68. 00 69. 00 06900 ELECTROCARDI OLOGY -186, 639 1, 137, 725 69. 00 69. 01 06901 CARDI AC REHAB -172 789, 676 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY -70 98, 224 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 27, 345, 652 73. 00 73. 01 073301 ULTRA SOUND -119 632, 597 73. 00 00TPATI ENT SERVI CE COST CENTERS <t< td=""></t<>
60. 00 06000 LABORATORY -336, 331 10, 373, 416 60. 00 64. 00 64.00 1NTRAVENOUS THERAPY -14, 401 1, 460, 543 65. 00 6500 RESPI RATORY THERAPY -779 3, 880, 946 65. 00 66
64. 00 06400 INTRAVENOUS THERAPY -14, 401 1, 460, 543 65. 00 06500 RESPIRATORY THERAPY -779 3, 880, 946 65. 00 66. 00 06600 PHYSI CAL THERAPY -784, 180 7, 832, 222 66. 00 06700 0CCUPATI ONAL THERAPY -48, 107 566, 965 68. 00 06800 SPEECH PATHOLOGY -22 386, 820 69. 00 06900 ELECTROCARDI OLOGY -186, 639 1, 137, 725 69. 01 06901 CARDI AC REHAB -172 789, 676 69. 01 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 27, 345, 652 73. 01 07301 ULTRA SOUND -119 632, 597 74. 00 07400 RENAL DI ALYSI S 0 0 479, 380 0 0 0 0 0 0 0 0 0
66. 00
67. 00 06700 0CCUPATI ONAL THERAPY -48, 107 566, 965 67. 00 68. 00 06800 SPEECH PATHOLOGY -22 386, 820 68. 00 69. 00 06900 ELECTROCARDI OLOGY -186, 639 1, 137, 725 69. 01 06901 CARDI AC REHAB -172 789, 676 69. 00 7000 ELECTROENCEPHALOGRAPHY -70 98, 224 70. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 07200 IMPL DEV. CHARGED TO PATI ENT 0 10, 998, 901 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 27, 345, 652 73. 01 07301 ULTRA SOUND -119 632, 597 74. 00 07400 RENAL DI ALYSI S 0 479, 380 0 0 0 0 0 0 0 0 0
68. 00
69. 00
69. 01 06901 CARDI AC REHAB -172 789, 676 70. 00 07000 ELECTROENCEPHALOGRAPHY -70 98, 224 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 0 10, 998, 901 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 27, 345, 652 73. 01 07301 ULTRA SOUND -119 632, 597 74. 00 00TPATI ENT SERVI CE COST CENTERS
70. 00 07000 ELECTROENCEPHALOGRAPHY -70 98, 224 70. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 10, 998, 901 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 27, 345, 652 73. 00 73. 01 07301 ULTRA SOUND -119 632, 597 74. 00 07400 RENAL DIALYSIS 0 479, 380 0 00TPATIENT SERVICE COST CENTERS
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 27, 345, 652 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 07400 RENAL DI ALYSIS 0 479, 380 74. 00 00TPATIENT SERVICE COST CENTERS
73. 01 07301 ULTRA SOUND -119 632, 597 74. 00 07400 RENAL DI ALYSI S 0 479, 380 74. 00 0UTPATI ENT SERVI CE COST CENTERS
74. 00 07400 RENAL DI ALYSI S 0 479, 380 74. 00 0UTPATI ENT SERVI CE COST CENTERS
OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY -5, 900, 179 7, 741, 679 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
SPECIAL PURPOSE COST CENTERS
118.00 SUBTOTALS (SUM OF LINES 1 through 117) -36,664,407 263,935,563 118.00
NONREI MBURSABLE COST CENTERS
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 71, 831, 605 192. 00
192. 0119201 HEALTH TRACKS 0 4, 260, 077 192. 01
194. 00 07950 PRIMARY CARE CLINIC 0 2, 625, 149 194. 00
194. 01 07951 PARTNERS IN CARE 0 3, 451 194. 01
194. 02 07952 OCCUPATI ONAL MEDI CI NE 0 1, 095, 448 194. 02 07053 EQUINDATI ON 104. 03 07053 EQUINDATI ON 104. 03
194. 03 07953 FOUNDATION 0 134, 114 194. 03 194. 04 07954 SCHOOL & TOWN CLINICS 0 2, 817, 823 194. 04
194. 04 07954 SCHOOL & TOWN CLINICS 0 2, 817, 823 194. 04 194. 05 07955 MANAGED FACILITY 0 624, 451 194. 05
194. 06 07956 RENTAL PROPERTIES 0 99, 154 194. 06
194. 07 07957 SNF NON CERTIFIED 0 1,543, 175 194. 07
200.00 TOTAL (SUM OF LINES 118 through 199) -36,664,407 348,970,010 200.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2021 To 12/31/2021 Provi der CCN: 15-0005 Date/Time Prepared: 5/26/2022 12:56 pm

					5/26/2022	12:56 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
4 00	A - DRUGS RECLASS	70.00		07.045.450		
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	27, 345, 652		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4. 00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11.00
12. 00		0.00	Ö	0		12.00
13. 00		0.00	Ö	0		13.00
14. 00		0.00	o	0		14. 00
15. 00		0.00	o	0		15. 00
16. 00		0. 00	o	Ö		16.00
17. 00		0.00	o	0		17. 00
18. 00		0. 00	o	0		18. 00
19.00		0.00	O	0		19.00
20.00		0. 00	O	0		20.00
21.00		0.00	O	0		21.00
22.00		0. 00	0	0		22. 00
23.00		0. 00	0	0		23.00
24.00		0. 00	0	0		24. 00
	TOTALS		0	27, 345, 652		
	B - MOB RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	29, 588		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	94, 702		2. 00
3.00	OPERATION OF PLANT	7. 00	0	71, 199		3. 00
4. 00	LAUNDRY & LINEN SERVICE	8. 00	0	45, 894		4. 00
5. 00	SOCIAL SERVICE	17. 00	0	4, 446		5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	78, 223		6. 00
7. 00	RADI ATI ON-ONCOLOGY	54. 01	0	115, 828		7. 00
8.00	LABORATORY	60.00	0	5, 466		8. 00
9.00	I NTRAVENOUS THERAPY	64.00	0	17, 818		9.00
10.00	PHYSI CAL THERAPY	66.00	0	27, 726		10.00
11.00	OCCUPATIONAL THERAPY	67. 00	0	27, 726		11.00
12. 00	CLINIC	9000	0	184, 716		12.00
	TOTALS C - CAFETERIA RECLASS		U	703, 332		
1. 00	CAFETERIA RECLASS	11. 00	1, 428, 003	1, 082, 990		1.00
1.00	TOTALS		1, 428, 003	1, 082, 990		1.00
	D - IMPLANTABLE DEVICE RECLAS	22	1, 420, 003	1,002,770		
1. 00	IMPL. DEV. CHARGED TO	72. 00	O	10, 998, 901		1.00
1.00	PATI ENT	72.00	٩	10, 770, 701		1.00
2.00	7.7.1	0. 00	o	0		2. 00
	TOTALS — — — —			10, 998, 901		
	E - BONUS/PTO RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	71, 405	0		1.00
2.00		0. 00	0	0		2. 00
3.00		0. 00	0	0		3.00
4.00		0. 00	0	0		4.00
5.00		0. 00	0	0		5.00
6.00		0.00	0	0		6. 00
7. 00		0. 00	0	0		7. 00
8. 00		0.00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10.00		0. 00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0. 00 0. 00	0	0		14.00
15.00		0.00	0	0		15. 00 16. 00
16. 00 17. 00		0.00	0	0		17.00
18. 00		0.00	0	0		18.00
19. 00		0.00	0	0		19.00
20. 00		0.00	0	0		20.00
21. 00		0.00	0	0		21.00
22. 00		0.00	o	0		22. 00
23. 00		0. 00	o	0		23. 00
24. 00		0. 00	o	0		24. 00
25. 00		0. 00	O	0		25. 00
				,		

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0005

					To 12/31/2021 Date/lime Pi 5/26/2022 12	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
26. 00	2. 00	3. 00	4. 00	5. 00		26. 00
27. 00		0.00	o	Ö		27. 00
28. 00		0.00	O	0		28. 00
29. 00		0.00	0	0		29. 00
30.00		0.00	0	0		30.00
31. 00 32. 00		0. 00 0. 00	0	0		31. 00 32. 00
33. 00		0.00	0	0		33.00
34. 00		0.00	Ö	0		34.00
35.00		0.00	О	0		35.00
36.00		0.00	0	0		36.00
37. 00 38. 00		0. 00 0. 00	0	0		37. 00 38. 00
39. 00		0.00	Ö	Ö		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
42.00		0.00	0	0		42.00
43. 00	TOTALS — — — — —					43. 00
	F - MEDICAL SUPPLY RECLASS		71, 400	<u> </u>		
1.00	OPERATING ROOM	50. 00	0	9, 372, 806		1.00
2.00		0. 00	0	0		2.00
3. 00 4. 00		0. 00 0. 00	0	0		3. 00 4. 00
5. 00		0.00	0	0		5.00
6. 00		0. 00	Ö	0		6.00
7. 00		0. 00	0	0		7.00
8. 00		0.00	0	0		8.00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	o	Ö		11.00
12.00		0. 00	0	0		12.00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	ol Ol	0		16.00
17. 00		0.00	Ö	Ö		17. 00
18.00		0. 00	0	0		18. 00
19.00		0.00	0	0		19.00
20. 00 21. 00		0. 00 0. 00	0	0		20. 00 21. 00
22. 00		0.00	Ö	Ö		22. 00
23. 00		0.00	O	0		23. 00
24.00		0.00	0	0		24.00
25. 00 26. 00		0. 00 0. 00	0	0		25. 00 26. 00
27.00		0.00	0	0		27.00
28. 00		0. 00	Ö	Ö		28. 00
29. 00		0.00	0	0		29. 00
30.00		0.00	0	0		30.00
31. 00 32. 00		0. 00 0. 00	0	0		31. 00 32. 00
02.00	TOTALS — — — — —		— — ö	9, 372, 806		02.00
	G - HEALTH INSURANCE RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00				1.00
	TOTALS H - CHILDBIRTH CENTER RECLASS	<u> </u>	U	887		
1. 00	NURSERY	43. 00	1, 527, 688	251, 332		1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52.00	2, 749, 052	452, 269		2.00
	TOTALS		4, 276, 740	703, 601		
1 00	I - MEDICAL DIRECTOR RECLASS	F 00	104 105			1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL	5. 00 0. 00	184, 185	0		1. 00 2. 00
2.00	TOTALS — — — — —		184, 185	$\frac{0}{0}$		2.00
	J - INTEREST EXPENSE RECLASS					
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	3, 844, 501		1.00
2.00	FI XT	0.00				2.00
2. 00	TOTALS — — — — —	0.00		3, 844, 501		2.00
	K - EMS EDUCATION RECLASS		Ŋ	5, 044, 501		1
1.00	PARAMED ED PRGM-EMS	23. 00	114, 743	79, 155		1.00
	TOTALS		114, 743	79, 155		
500.00	Grand Total: Increases		6, 075, 076	54, 131, 825		500.00

Health Financial Systems			HENDRICKS REGIONAL HEALTH				In Lieu of Form CMS-2552		
RECLAS	SIFICATIONS			Provi der CO		Peri od:	Worksheet	A-6	
						From 01/01/2021 To 12/31/2021	Date/Ti me	Prepared:	
		Dooroooo					5/26/2022	12:56 pm	
	Cost Center	Decreases Li ne #	Sal ary	Other W	Wkst. A-7 Ref.				
	6.00	7. 00	8. 00	9. 00	10. 00				
	A - DRUGS RECLASS								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	117, 389	0			1.00	
2. 00 3. 00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	0	86, 971 3	0			2. 00 3. 00	
4. 00	HOUSEKEEPI NG	9.00	0	5	0			4. 00	
5. 00	NURSI NG ADMI NI STRATI ON	13. 00	o	364, 318	0			5. 00	
6.00	CENTRAL SERVICES & SUPPLY	14. 00	О	12, 100	0			6. 00	
7. 00	PHARMACY	15. 00	0	26, 353, 958	0			7. 00	
8. 00	ADULTS & PEDIATRICS	30.00	0	7, 010	0			8.00	
9. 00 10. 00	INTENSIVE CARE UNIT OPERATING ROOM	31. 00 50. 00	0	2, 457 41, 492	0			9. 00 10. 00	
11. 00	ENDOSCOPY	50. 00	o	5, 330	0			11.00	
12. 00	RECOVERY ROOM	51.00	o	11, 297	0			12. 00	
13.00	ANESTHESI OLOGY	53. 00		99	0			13.00	
14.00	RADI OLOGY-DI AGNOSTI C	54.00		243, 533	0			14. 00	
15.00	RADI ATI ON-ONCOLOGY	54. 01		1, 396	0			15.00	
16. 00 17. 00	NUCLEAR MEDICINE CARDIAC CATHETERIZATION	56. 01 59. 00		10, 613 12, 558	0			16. 00 17. 00	
18. 00	LABORATORY	60.00		193	0			18. 00	
19. 00	INTRAVENOUS THERAPY	64. 00	•	18	0			19. 00	
20.00	RESPI RATORY THERAPY	65. 00		7, 259	0			20. 00	
21.00	PHYSI CAL THERAPY	66. 00		57, 691	0			21. 00	
22. 00	ELECTROCARDI OLOGY	69. 00		1, 631	0			22. 00	
23. 00	CLI NI C	90.00		4, 418	0			23.00	
24. 00	EMERGENCY	91.00		<u>3, 913</u> 27, 345, 652	0			24. 00	
	B - MOB RECLASS		<u> </u>	27, 343, 032					
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	703, 332	0			1.00	
2.00		0. 00	О	0	0			2. 00	
3. 00	1	0.00	0	0	0			3. 00	
4. 00		0.00	0	0	0			4.00	
5. 00 6. 00	+	0. 00 0. 00	0	0	0			5. 00 6. 00	
7. 00		0.00	0	0	0			7. 00	
8. 00		0.00	O	Ō	0			8. 00	
9.00		0. 00	О	0	0			9. 00	
10.00		0. 00	0	0	0			10.00	
11.00		0.00	0	0	0			11.00	
12. 00	TOTALS — — — — —			703, 332				12.00	
	C - CAFETERIA RECLASS		<u> </u>	700,002					
1.00	DI ETARY	10.00	1, 428, 003	1, 082, 990	0			1.00	
	TOTALS		1, 428, 003	1, 082, 990					
1 00	D - IMPLANTABLE DEVICE RECLAS		ol	0.0(2.(22				1.00	
1. 00 2. 00	OPERATING ROOM CLINIC	50. 00 90. 00	0	9, 963, 632 1, 035, 269	0			1. 00 2. 00	
2.00	TOTALS — — — —	70.00	— — —	10, 998, 901				2.00	
	E - BONUS/PTO RECLASS		<u> </u>	10/ //0/ /01					
1.00	ADMINISTRATIVE & GENERAL	5. 00	6, 533	0	0			1.00	
2.00	OPERATION OF PLANT	7. 00	1, 170	0	0			2. 00	
3.00	LAUNDRY & LINEN SERVICE	8. 00	146	0	0			3.00	
4. 00 5. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	1, 243 247	0	0			4. 00 5. 00	
6. 00	CAFETERI A	11. 00	594	0	0			6. 00	
7. 00	NURSI NG ADMI NI STRATI ON	13. 00	2, 070	Ö	0			7. 00	
8.00	CENTRAL SERVICES & SUPPLY	14. 00	478	0	0			8. 00	
9. 00	PHARMACY	15. 00	1, 154	0	0			9. 00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	209	0	0			10.00	
11. 00 12. 00	SOCIAL SERVICE ADULTS & PEDIATRICS	17. 00 30. 00	827 6, 351	0	0			11. 00 12. 00	
13. 00	INTENSIVE CARE UNIT	31.00	1, 198	0	0			13.00	
14. 00	NURSERY	43. 00	589	Ö	0			14. 00	
15. 00	OPERATING ROOM	50. 00	1, 155	Ō	0			15. 00	
16. 00	ENDOSCOPY	50. 01	466	0	0			16. 00	
17. 00	RECOVERY ROOM	51.00	700	0	0			17.00	
18. 00 19. 00	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	52. 00 53. 00	1, 141 3, 105	0	0			18. 00 19. 00	
20.00	RADI OLOGY – DI AGNOSTI C	54.00	3, 105 2, 725	0	0			20.00	
21. 00	RADI ATI ON-ONCOLOGY	54. 00	371	0	0			21.00	
22. 00	NUCLEAR MEDICINE	56. 01	117	Ö	0			22. 00	
23.00	CARDIAC CATHETERIZATION	59. 00	278	0	0			23. 00	
24.00	LABORATORY	60.00	1, 539	0	0			24.00	
25.00	I NTRAVENOUS THERAPY	64.00	611	0	0			25. 00	
26. 00	RESPI RATORY THERAPY	65. 00	1, 113	0	0]		26.00	

In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2021 To 12/31/2021

Date/Time Prepared: 5/26/2022 12:56 pm

					L.	5/26/2022 12	:56 pm
	0	Decreases	C-1	0+4	WI+ A 7 D-E		
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
27.00	6.00	7.00	8. 00	9. 00	10.00		27.00
27. 00	PHYSI CAL THERAPY	66.00	2, 874	0	0		27.00
28. 00	OCCUPATIONAL THERAPY	67.00	226	0	0		28.00
29. 00	SPEECH PATHOLOGY	68.00	148	0	0		29.00
30.00	ELECTROCARDI OLOGY	69.00	413	=	- 1		30.00
31.00	CARDI AC REHAB	69. 01	301	0	0		31.00
32.00	ELECTROENCEPHALOGRAPHY	70.00	38	0	0		32.00
33.00	ULTRA SOUND	73. 01	244	0	0		33.00
34.00	CLI NI C	90.00	656	0	0		34.00
35. 00	EMERGENCY	91.00	4, 971	0	0		35.00
36.00	PHYSICIANS' PRIVATE OFFICES	192.00	21, 614	0	0		36.00
37.00	HEALTH TRACKS	192. 01	1, 404	0	0		37.00
38. 00	PRIMARY CARE CLINIC	194. 00	601	0	0		38.00
39. 00	OCCUPATIONAL MEDICINE	194. 02	221	0	0		39.00
40.00	FOUNDATION	194. 03	50	0	0		40.00
41.00	SCHOOL & TOWN CLINICS	194. 04	804	0	0		41.00
42.00	MANAGED FACILITY	194. 05	178	0	0		42.00
43.00	SNF NON CERTIFIED	<u> </u>	532	0	0		43.00
	TOTALS		71, 405	0			-
4 00	F - MEDI CAL SUPPLY RECLASS			45 440			4
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45, 148	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	64, 545	0		2.00
3. 00	OPERATION OF PLANT	7. 00	0	3, 884	0		3. 00
4. 00	LAUNDRY & LINEN SERVICE	8. 00	0	117, 002	0		4. 00
5. 00	HOUSEKEEPI NG	9. 00	0	100, 910	0		5. 00
6. 00	DI ETARY	10. 00	0	14, 427	0		6. 00
7. 00	NURSING ADMINISTRATION	13. 00	0	37, 349	0		7. 00
8. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	1, 105, 699	0		8. 00
9. 00	PHARMACY	15. 00	0	145, 184	0		9. 00
10. 00	SOCIAL SERVICE	17. 00	0	739	0		10.00
11. 00	ADULTS & PEDIATRICS	30.00	0	896, 303	0		11.00
12. 00	INTENSIVE CARE UNIT	31. 00	0	593, 476	0		12.00
13. 00	ENDOSCOPY	50. 01	0	549, 724	0		13.00
14. 00	RECOVERY ROOM	51.00	0	217, 729	0		14. 00
15. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	35, 925	0		15.00
16. 00	ANESTHESI OLOGY	53. 00	0	262, 467	0		16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	876, 639	0		17.00
18. 00	RADI ATI ON-ONCOLOGY	54. 01	0	43, 236	0		18. 00
19. 00	NUCLEAR MEDICINE	56. 01	0	31, 370	0		19.00
20. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	2, 031, 502	0		20.00
21. 00	LABORATORY	60.00	0	421, 405	0		21.00
22. 00	I NTRAVENOUS THERAPY	64. 00	0	293, 463	0		22. 00
23. 00	RESPI RATORY THERAPY	65. 00	0	275, 547	0		23.00
24.00	PHYSI CAL THERAPY	66. 00	0	228, 529	0		24.00
25.00	OCCUPATI ONAL THERAPY	67.00	0	7, 967	0		25. 00
26. 00	SPEECH PATHOLOGY	68. 00	0	2, 490	0		26. 00
27. 00	ELECTROCARDI OLOGY	69. 00	0	213, 851	0		27. 00
28. 00	CARDI AC REHAB	69. 01	0	12, 819	0		28. 00
29. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	5, 275	0		29. 00
30.00	ULTRA SOUND	73. 01	0	33, 918	0		30.00
31.00	CLINIC	90.00	0	3, 663	0		31.00
32.00	EMERGENCY	91.00		70 <u>0, 6</u> 21	0		32.00
	TOTALS		0	9, 372, 806			1
	G - HEALTH INSURANCE RECLASS						
1.00	PHYSICAL THERAPY	<u>66.</u> 00	•		0		1.00
	TOTALS		0	887			_
	H - CHILDBIRTH CENTER RECLAS						
1. 00	ADULTS & PEDIATRICS	30.00	4, 276, 740	703, 601	0		1.00
2. 00	L	0.00	0_	0	0		2.00
	TOTALS		4, 276, 740	703, 601			_
	I - MEDICAL DIRECTOR RECLASS						
1. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	178, 147	0	0		1.00
2. 00	SCHOOL & TOWN CLINICS	<u> </u>	<u>6, 0</u> 38	0	0		2.00
	TOTALS		184, 185	0]
	J - INTEREST EXPENSE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 798, 216			1.00
2.00	NURSING ADMINISTRATION	1300	0	4 <u>6, 2</u> 85	0		2.00
	TOTALS		0	3, 844, 501]
	K - EMS EDUCATION RECLASS						
1.00	EMERGENCY	91.00	11 <u>4, 7</u> 43	7 <u>9, 1</u> 55	0		1.00
	TOTALS		114, 743	79, 155			
500.00	Grand Total: Decreases	Ι	6, 075, 076	54, 131, 825			500.00

				Ť	o 12/31/2021	Date/Time Pre 5/26/2022 12:	pared: 56 pm
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	18, 926, 206	401, 594	0	401, 594	0	1.00
2.00	Land Improvements	9, 993, 537	168, 097	0	168, 097	0	2.00
3.00	Buildings and Fixtures	297, 514, 437	3, 313, 984	0	3, 313, 984	0	3.00
4. 00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	144, 853, 391	9, 028, 851	0	9, 028, 851	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	471, 287, 571	12, 912, 526	0	12, 912, 526	0	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	471, 287, 571	12, 912, 526	0	12, 912, 526	0	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	19, 327, 800	0				1.00
2. 00	Land Improvements	10, 161, 634	0				2.00
3. 00	Buildings and Fixtures	300, 828, 421	0				3.00
4.00	Building Improvements	0	0				4.00
5. 00	Fi xed Equi pment	153, 882, 242	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	484, 200, 097	0				8.00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	484, 200, 097	0				10.00

Heal th	Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	2552-10	
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0005	Peri od: From 01/01/2021 To 12/31/2021		pared:
			SUMMARY OF CAPITAL				
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	24, 721, 269	0)	0 0	0	1.00
3.00	Total (sum of lines 1-2)	24, 721, 269	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1)	1			
	·	Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00	1			
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	24, 721, 269		-		1.00
3.00	Total (sum of lines 1-2)	0	24, 721, 269				3.00
		•	•	•			•

Heal th	Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	2552-10	
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
					From 01/01/2021 To 12/31/2021	Part III Date/Time Pre	nared·
					12/01/2021	5/26/2022 12:	
		COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
	Cook Cooker December 1				Dati - (1	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
			Leases	(col. 1 -	Tristructions)		
				col . 2)			
		1. 00	2.00	3.00	4.00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	484, 200, 097		484, 200, 097			1.00
3. 00	Total (sum of lines 1-2)	484, 200, 097		484, 200, 097			3.00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
	Cost Conton Decemintion	Toyoo	Other	Total (our of	Donnooiation	Lanna	
	Cost Center Description	Taxes	Capi tal -Rel at	Total (sum of cols. 5	Depreciation	Lease	
			ed Costs	through 7)			
		6, 00	7.00	8.00	9, 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		2.22			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	(24, 794, 644	0	1.00
3.00	Total (sum of lines 1-2)	0	0	(24, 794, 644	0	3.00
			SL	JMMARY OF CAPI	TAL		
					1		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see instructions)	9 through 14)	
		11. 00	12.00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	10.00	14.00	13.00	
1. 00	NEW CAP REL COSTS-BLDG & FIXT	3, 119, 888	0		0	27, 914, 532	1.00
3.00	Total (sum of lines 1-2)	3, 119, 888			0	27, 914, 532	3.00

				To	12/31/2021	Date/Time Pre 5/26/2022 12:	
				Expense Classification on To/From Which the Amount is 1			ос рііі
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	В	-724, 613	NEW CAP REL COSTS-BLDG & FIXT	1. 00	11	1. 00
2. 00	2) Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter 21)		0		0. 00	0	7. 00
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking lot (chapter 21) Provi der-based physician adjustment	A-8-2	0 -20, 101, 730		0. 00	0 0	
11. 00	1 3		0		0. 00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13. 00 14. 00 15. 00	Laundry and linen service Cafeteria-employees and guests Rental of quarters to employee	В	-937, 573 0	CAFETERI A	0. 00 11. 00 0. 00	0 0 0	14.00
16. 00	and others Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,	В	-41, 941	PARAMED ED PRGM-EMS	23. 00	0	19. 00
20. 00 21. 00	books, etc.) Vending machines Income from imposition of interest, finance or penalty charges (chapter 21)		0		0. 00 0. 00	0	
22. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0. 00	0	22. 00
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP			FIXT *** Cost Center Deleted ***	2. 00	0	27. 00
28. 00 29. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	o O	OCCUPATI ONAL THERAPY	67. 00	-	30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99

				To	o 12/31/2021	Date/Time Pre 5/26/2022 12:	
				Expense Classification on	Worksheet A	3/20/2022 12.	Jo pili
				To/From Which the Amount is			
					,		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)	2.00	2.00	4.00	Ref.	
21 00	Adjustment for anach	1. 00 A-8-3	2.00	3.00 SPEECH PATHOLOGY	4. 00	5. 00	31.00
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHULUGY	68. 00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32.00
32.00	Depreciation and Interest				0.00	O	32.00
33. 00	1993 CARRYFORWARD	А	70. 087	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 00
			,	FIXT			
33. 01	1994 CARRYFORWARD	A	3, 288	NEW CAP REL COSTS-BLDG &	1.00	9	33. 01
				FIXT			
33. 02	ADMITTING TELEPHONE	Α	-2, 028	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
	(EQUI PMENT)						
33. 03	ADMITTING TELEPHONE (SALARY)	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04	MARKETING DEPARTMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 05	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 06	I HA LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 07	AHA LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 08	HOSPITAL ASSESSMENT FEE	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 09	HIP ASSESSMENT FEE	A	-5, 602, 330	ADMINISTRATIVE & GENERAL	5. 00	0	
33. 10	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 10
00.44	(3)		00.000	EMPLOYEE DENEEL TO DEDARTMENT	4 00		00.44
33. 11	MISC INCOME	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	
33. 12	MISC INCOME	B B		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 13 33. 14	MISC INCOME MISC INCOME	В		OPERATION OF PLANT	7. 00	0	
33. 15	MISC INCOME	В		LAUNDRY & LINEN SERVICE HOUSEKEEPING	8. 00 9. 00	0	
33. 16	MISC INCOME	В		NURSING ADMINISTRATION	13. 00	0	
33. 17	MISC INCOME	В		CENTRAL SERVICES & SUPPLY	14. 00	0	
33. 18	MISC INCOME	В		PHARMACY	15. 00	0	
33. 19	MISC INCOME	В		MEDICAL RECORDS & LIBRARY	16. 00	0	1
33. 20	MISC INCOME	В		SOCI AL SERVI CE	17. 00	0	1
33. 21	MISC INCOME	В		ADULTS & PEDIATRICS	30. 00	0	1
33. 22	MISC INCOME	В		INTENSIVE CARE UNIT	31. 00	0	
33. 23	MISC INCOME	В		OPERATING ROOM	50.00	0	1
33. 24	MISC INCOME	В		ENDOSCOPY	50. 01	0	33. 24
33. 25	MISC INCOME	В	-390	RECOVERY ROOM	51.00	0	33. 25
33. 26	MISC INCOME	В	-201	ANESTHESI OLOGY	53. 00	0	33. 26
33. 27	MISC INCOME	В	-438	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 27
33. 28	MISC INCOME	В	-500	RADI ATI ON-ONCOLOGY	54. 01	0	33. 28
33. 29	MISC INCOME	В		NUCLEAR MEDICINE	56. 01	0	
33. 30	MISC INCOME	В		CARDIAC CATHETERIZATION	59. 00	0	
	MISC INCOME	В		LABORATORY	60. 00	0	
33. 32	MISC INCOME	В	· ·	INTRAVENOUS THERAPY	64. 00	0	
33. 33	MISC INCOME	В		RESPI RATORY THERAPY	65. 00	0	
33. 34	MISC INCOME	В		PHYSI CAL THERAPY	66.00	0	
33. 35	MISC INCOME	В		OCCUPATIONAL THERAPY	67. 00	0	
33. 36	1	В		SPEECH PATHOLOGY	68. 00	0	
33. 37	MISC INCOME	В		ELECTROCARDI OLOGY	69. 00	0	
33. 38	MISC INCOME	В		CARDI AC REHAB ELECTROENCEPHALOGRAPHY	69. 01	0	
33. 39 33. 40	MISC INCOME MISC INCOME	B B		ULTRA SOUND	70.00	0	
33. 40	MLSC INCOME	l B		EMERGENCY	73. 01 91. 00	0	
50. 00	TOTAL (sum of lines 1 thru 49)	٥	-932 -36, 664, 407		91.00	U	50.00
50.00	(Transfer to Worksheet A,		30,004,407				30.00
	column 6, line 200.)						
	100. 0 0, 11110 200.)						

⁽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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0005

						10 12/31/2021	5/26/2022 12:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l 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		EMPLOYEE BENEFITS DEPARTMENT	444, 110				4, 417	1.00
2.00		ADMINISTRATIVE & GENERAL	346, 892		,		1, 866	
3.00		NURSING ADMINISTRATION	0	0	_		0	3.00
4. 00		SOCIAL SERVICE	4 400 010	4 400 010	0	,	0	4.00
5. 00		ADULTS & PEDIATRICS	4, 439, 818			211, 500	0	5.00
6. 00 7. 00		INTENSIVE CARE UNIT OPERATING ROOM	185, 767 401	185, 767 401		211, 500 246, 400	0	6. 00 7. 00
8. 00		ANESTHESI OLOGY	8, 353, 091	8, 353, 091		239, 400	0	8. 00
9. 00		RADI OLOGY-DI AGNOSTI C	122, 916			271, 900	0	9. 00
10. 00		LABORATORY	86, 902			260, 300	0	10.00
11. 00		RESPIRATORY THERAPY	00, 702			211, 500	0	11. 00
12. 00		PHYSI CAL THERAPY	664, 133	1	_	211, 500	0	12.00
13. 00		ELECTROCARDI OLOGY	186, 265			211, 500	o O	13. 00
14. 00		CLI NI C	363			211, 500	0	14. 00
15. 00		EMERGENCY	5, 899, 247	5, 899, 247		211, 500	0	15. 00
200.00	71.00	Emerica i	20, 729, 905				6, 283	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
4.00	1.00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	4.00
1. 00 2. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	449, 133				0	1. 00 2. 00
3. 00		NURSING ADMINISTRATION	189, 740 0	1			0	3. 00
4. 00		SOCIAL SERVICE			-	0	0	4. 00
5. 00		ADULTS & PEDIATRICS			_	0	0	5. 00
6. 00		INTENSIVE CARE UNIT	0		0	0	0	6. 00
7. 00		OPERATING ROOM	0		0	0	0	7. 00
8. 00		ANESTHESI OLOGY	Ö		Ö	Ö	o o	8. 00
9. 00		RADI OLOGY-DI AGNOSTI C	0	O	0	0	0	9. 00
10. 00	60.00	LABORATORY	0	C	0	0	0	10.00
11. 00	65. 00	RESPIRATORY THERAPY	0	0	0	0	0	11.00
12.00	66. 00	PHYSICAL THERAPY	0	0	0	0	0	12.00
13.00	69. 00	ELECTROCARDI OLOGY	0	0	0	0	0	13.00
14. 00		CLINIC	0	0	0	0	0	14.00
15. 00	91. 00	EMERGENCY	0	0	0	0	0	15.00
200.00	MI	01 01(D	638, 873			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		EMPLOYEE BENEFITS DEPARTMENT	0		0	5, 674		1.00
2.00	5. 00	ADMINISTRATIVE & GENERAL	0	189, 740	157, 152	157, 152		2.00
3. 00		NURSING ADMINISTRATION	0	0	0	0		3.00
4. 00		SOCIAL SERVICE	0	0	0	0		4. 00
5. 00		ADULTS & PEDIATRICS	0	1		.,,		5. 00
6. 00		INTENSIVE CARE UNIT	0					6. 00
7. 00		OPERATING ROOM	0					7.00
8. 00		ANESTHESI OLOGY	0		-	.,		8.00
9. 00		RADI OLOGY-DI AGNOSTI C	0			122, 916		9.00
10. 00 11. 00		LABORATORY RESPIRATORY THERAPY			Ţ.	86, 902		10.00
12.00		PHYSICAL THERAPY			-	664, 134		11. 00 12. 00
12.00		ELECTROCARDI OLOGY			_	186, 265		12.00
14. 00		CLI NI C			-	1		14.00
15. 00		EMERGENCY						15. 00
200.00			Ö			1		200.00
200.00	1	l		, 555, 575	107, 102	20, 101, 700	1	_55.00

In Lieu of Form CMS-2552-10 Health Financial Systems HENDRICKS REGIONAL HEALTH COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0005 Peri od: Worksheet B From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 12:56 pm CAPI TAL RELATED COSTS ADMI NI STRATI V Cost Center Description Net Expenses NEW BLDG & **EMPLOYEE** Subtotal for Cost FLXT **BENEFITS** F & GENERAL DEPARTMENT Allocation (from Wkst A col. 7) 0 1.00 4.00 4A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 27, 914, 532 27, 914, 532 1 00 00400 EMPLOYEE BENEFITS DEPARTMENT 27, 274, 846 359, 378 27, 634, 224 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 41, 951, 769 1, 966, 593 2, 528, 475 46, 446, 837 46, 446, 837 5.00 5.00 00700 OPERATION OF PLANT 2, 675, 092 7.00 7.00 13, 235, 638 3, 735, 230 452.810 17, 423, 678 8.00 00800 LAUNDRY & LINEN SERVICE 36,666 307, 825 56, 585 401, 076 61, 578 8.00 9.00 00900 HOUSEKEEPI NG 3, 842, 954 144, 366 481, 161 4, 468, 481 686, 055 9.00 1, 666, 660 01000 DI ETARY 1, 028, 966 255, 886 10.00 10 00 542, 125 95 569 291, 563 01100 CAFETERI A 1, 899, 040 11.00 1, 572, 826 96, 276 229, 938 11.00 13.00 01300 NURSING ADMINISTRATION 7, 053, 587 280, 221 800, 908 8, 134, 716 1, 248, 939 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 1, 634, 545 523, 322 185, 175 2, 343, 042 359, 732 14.00 01500 PHARMACY 4, 377, 368 3 709 320 221, 258 446, 790 672,066 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 1, 324, 730 175, 660 80, 774 1, 581, 164 242, 759 16.00 01700 SOCIAL SERVICE 2, 224, 140 320, 144 2, 574, 575 395, 280 17.00 17.00 30, 291 02300 PARAMED ED PRGM-EMS 64, 659 151, 957 18, 484 235, 100 23.00 23.00 36, 095 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 12, 648, 730 2, 465, 515 2, 438, 633 17, 552, 878 2, 694, 928 30.00 03100 INTENSIVE CARE UNIT 31.00 3, 602, 882 285, 140 463, 520 4, 351, 542 668, 101 31.00 04300 NURSERY 1, 778, 431 53, 979 245, 997 2, 078, 407 319, 102 43 00 43 00

Peri od: Worksheet B From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 12:56 pm

				10	12/31/2021	5/26/2022 12:	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7. 00	8. 00	9. 00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00 16. 00 17. 00 23. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	20, 098, 770 0 261, 911 1, 027, 526 182, 479 531, 122 950, 302 419, 365 332, 940 0 122, 552	462, 654 0 0 0 0 0 519 0 0	5, 416, 447 27, 651 119, 819 27, 651 9, 217 18, 434 0 3, 072	2, 977, 723 0 0 0 0 0 0 0	2, 492, 901 129, 231 62, 086 83, 252 25, 762 67, 456 20, 992	13. 00 14. 00 15. 00 16. 00 17. 00
00.00	INPATIENT ROUTINE SERVICE COST CENTERS	4 04 (504	100.000	040 (44	0.04/ 77/	205 544	00.00
30. 00 31. 00 43. 00 44. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	4, 316, 504 540, 445 102, 311 0	108, 233 31, 957 10, 785 0	328, 735 12, 289	2, 046, 776 383, 971 278, 471 0	385, 511 78, 973 53, 608	31. 00 43. 00
50.00	05000 OPERATI NG ROOM	1, 377, 702	15, 438	224, 277	0	102, 546	50.00
50. 01 51. 00 52. 00 53. 00 54. 01 56. 00 56. 01 59. 00 64. 00 65. 00 66. 00 67. 00 69. 00	05001 ENDOSCOPY 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 054001 RADI OLOGY-DI AGNOSTI C 05401 RADI ATI ON-ONCOLOGY 05600 RADI OI SOTOPE 05601 NUCLEAR MEDI CI NE 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 069001 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	953, 553 1, 681, 323 673, 670 0 1, 067, 334 0 32, 325 584, 731 676, 369 204, 070 629, 200 468, 925 26, 559 145, 677 256, 759 181, 314	23, 035 32, 475 19, 408 0 55, 311 3, 716 0 0 4, 784 37 0 25, 578 0 7, 150	116, 747 110, 602 153, 614 6, 145 368, 675 95, 241 0 9, 217 61, 446 255, 000 43, 012 43, 012 503, 856 46, 084 18, 434 49, 157		37, 841 51, 775 96, 466 67, 528 218, 835 34, 169 0 8, 959 23, 136 175, 324 44, 927 88, 218 247, 966 17, 960 11, 413 50, 464	50. 01 51. 00 52. 00 53. 00 54. 00 54. 01 56. 00 56. 01 59. 00 60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	164, 507	475		Ö	3, 839	
71. 00 72. 00 73. 00 73. 01 74. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 07301 ULTRA SOUND 07400 RENAL DIALYSIS 0UTPATIENT SERVICE COST CENTERS	0 0 0 41, 832 0	0 0 0 0 68	0 0 9, 217	0 0 0 0 0	0 0 0 18, 366 9	72. 00 73. 00 73. 01
	09000 CLI NI C	0	19, 006		0	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	1, 264, 534	72, 426	497, 711	0	217, 625	91.00 92.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	19, 217, 841	430, 467	4, 439, 459	2, 709, 218	2, 449, 529	118. 00
102.00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES	70, 047	16, 749	672, 831	0	0	192. 00
192. 01 194. 00 194. 01 194. 02 194. 04 194. 05 194. 06	19201 HEALTH TRACKS 07950 PRIMARY CARE CLINIC 07951 PARTNERS IN CARE 07952 OCCUPATIONAL MEDICINE 07953 FOUNDATION 07954 SCHOOL & TOWN CLINICS 07955 MANAGED FACILITY 07956 RENTAL PROPERTIES 07957 SNF NON CERTIFIED	0 0 0 0 0 0 0 0 0 0 0 0	3, 290 2, 394 0 516 0 226 0 9, 012	135, 181 95, 241 0 64, 518 3, 072 6, 145 0	0 0 0 0 0 0 0 0 0 0 0 268, 505	0 0 0 0 0 0	192. 01 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06
201.00	Negative Cost Centers	0 20, 098, 770	0 462, 654	0 5, 416, 447	0 2, 977, 723	0 2, 492, 901	201.00

| Peri od: | Worksheet B | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared:

				10	5 12/31/2021	Date/IIme Pre 5/26/2022 12:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	<u> Бин</u>
		ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
		N	SUPPLY	15.00	LI BRARY	17.00	
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	10, 071, 659	0.704.070				13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY	0	3, 724, 379 0	E E71 004			14.00
16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY		0	5, 571, 004 0	2, 182, 625		15. 00 16. 00
17. 00	01700 SOCIAL SERVICE		o	0	2, 102, 029	3, 040, 383	17. 00
23. 00	02300 PARAMED ED PRGM-EMS	0	o	0	o	0, 010, 000	1
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>		20.00
30.00	03000 ADULTS & PEDIATRICS	2, 471, 255	0	0	161, 635	1, 508, 365	30.00
31.00	03100 INTENSIVE CARE UNIT	506, 249	0	0	60, 099	282, 932	31.00
43.00	04300 NURSERY	343, 645	0	0	40, 898	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
F0 00	ANCI LLARY SERVI CE COST CENTERS	(57.0(0)	2 704 270	0	44. 0.4	007.045	F0 00
50.00	O5000 OPERATI NG ROOM O5001 ENDOSCOPY	657, 360	3, 724, 379	0	416, 864	937, 345	1
50. 01 51. 00	05100 RECOVERY ROOM	242, 575 331, 896	0	0	71, 772 68, 365	0	50. 01 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	618, 385	0	0	73, 596	0	52.00
53. 00	05300 ANESTHESI OLOGY	432, 882	0	0	70,070	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 402, 813	ō	0	72, 268	0	54.00
54.01	05401 RADI ATI ON-ONCOLOGY	0	o	0	124, 198	0	54. 01
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
56. 01	05601 NUCLEAR MEDI CI NE	57, 429	0	0	0	0	56. 01
59. 00	05900 CARDI AC CATHETERI ZATI ON	148, 313	0	0	175, 431	0	59.00
60.00	06000 LABORATORY	0	0	0	343, 347	0	60.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	565, 512	0	0	95, 517	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	363, 312	ol	0	54, 501	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	9, 085	0	67.00
68. 00	06800 SPEECH PATHOLOGY	o	o	0	5, 901	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	323, 492	О	0	48, 542	0	69. 00
69. 01	06901 CARDI AC REHAB	162, 134	0	0	5, 556	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73. 00 73. 01	O7300 DRUGS CHARGED TO PATIENTS O7301 ULTRA SOUND	0	0	5, 571, 004 0	0	0	73. 00 73. 01
74. 00	07400 RENAL DI ALYSI S	60	0	0	1, 535	0	1
7 1. 00	OUTPATIENT SERVICE COST CENTERS		₀	<u> </u>	1, 000		, 1. 00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
	09100 EMERGENCY	1, 529, 625	0	0	353, 515	311, 741	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
440.00	SPECIAL PURPOSE COST CENTERS	0.700.405	0.704.070	oo4	0 400 (05	0.040.000	
118. 00	,	9, 793, 625	3, 724, 379	5, 571, 004	2, 182, 625	3, 040, 383	1118.00
102.00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	ol	0	ol	0	192. 00
	19201 HEALTH TRACKS		ol	0	0		192.00
	07950 PRIMARY CARE CLINIC	0	ő	0	0		194. 00
	07951 PARTNERS IN CARE	o	o	0	o		194. 01
194. 02	07952 OCCUPATI ONAL MEDI CI NE	O	0	0	0		194. 02
194. 03	07953 FOUNDATI ON	0	O	0	o		194. 03
	07954 SCHOOL & TOWN CLINICS	0	0	0	0		194. 04
	07955 MANAGED FACILITY	0	0	0	0		194. 05
	07956 RENTAL PROPERTIES	0 0 00 1	0	0	0		194.06
194. 07 200. 00	O7957 SNF NON CERTIFIED Cross Foot Adjustments	278, 034	O	O	O	0	194. 07 200. 00
200.00			0	0	0	0	200.00
202.00		10, 071, 659	3, 724, 379	5, 571, 004	2, 182, 625	3, 040, 383	
202.00	1.07.12 (33 1.1.33 110 till dagit 201)		5, 721, 077	3, 3, 1, 004	2, 102, 020	5, 510, 505	,_02.00

Health Financial Systems	HENDRICKS REGIO	ONAL HEALIH		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		riod: om 01/01/2021 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/26/2022 12:56 pm
Cost Center Description	PARAMED ED PRGM-EMS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	23. 00	24. 00	25. 00	26. 00	
GENERAL SERVICE COST CENTERS	T. T.				
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE 23. 00 02300 PARAMED ED PRGM-EMS I NPATI ENT ROUTI NE SERVI CE COST CENTERS	414, 739				1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 23.00
30. 00 03000 ADULTS & PEDIATRICS	0	32, 164, 699	0	32, 164, 699	30.00
31. 00 03100 INTENSI VE CARE UNIT 43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0 0	7, 233, 004 3, 239, 516 0	0 0	7, 233, 004 3, 239, 516 0	31. 00 43. 00 44. 00
50. 00 05000 OPERATING ROOM	O	27, 258, 067	0	27, 258, 067	50.00
50. 01 05001 ENDOSCOPY 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 RADI ATI ON-ONCOLOGY 56. 00 05600 RADI OI SOTOPE 56. 01 05601 NUCLEAR MEDI CI NE 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 701, 913 5, 742, 548 6, 248, 875 1, 659, 472 15, 299, 267 3, 779, 403 0 838, 509 2, 594, 849 14, 641, 832 2, 511, 785 6, 823, 042 12, 531, 565 1, 122, 995 782, 257 2, 388, 405 1, 676, 526 442, 118		3, 701, 913 5, 742, 548 6, 248, 875 1, 659, 472 15, 299, 267 3, 779, 403 0 838, 509 2, 594, 849 14, 641, 832 2, 511, 785 6, 823, 042 12, 531, 565 1, 122, 995 782, 257 2, 388, 405 1, 676, 526 442, 118	50. 01 51. 00 52. 00 53. 00 54. 00 54. 01 56. 00 56. 01 59. 00 60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 01 70. 00 71. 00
73.00 07300 DRUGS CHARGED TO PATTENTS	0	12, 687, 584 37, 115, 089	0	12, 687, 584 37, 115, 089	73.00
73. 01 07301 ULTRA SOUND	o o	933, 413	Ö	933, 413	73. 01
74. 00 07400 RENAL DIALYSIS	0	566, 999	0	566, 999	74. 00
90. 00 09100 CLI NI C 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	0 414, 739	6, 772, 459 17, 011, 004	0 0 0	6, 772, 459 17, 011, 004	90. 00 91. 00 92. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	414, 739	227, 767, 195	0	227, 767, 195	118. 00
NONREI MBURSABLE COST CENTERS	1 -1				
192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192. 01 19201 HEALTH TRACKS 194. 00 07950 PRI MARY CARE CLINIC 194. 01 07951 PARTNERS IN CARE 194. 02 07952 OCCUPATIONAL MEDICINE 194. 03 07953 FOUNDATION 194. 04 07954 SCHOOL & TOWN CLINICS 194. 05 07955 MANAGED FACILITY	0 0 0 0 0 0	100, 848, 673 6, 177, 194 3, 811, 537 3, 981 1, 589, 784 209, 003 3, 658, 381 799, 655	0 0 0 0 0 0 0	100, 848, 673 6, 177, 194 3, 811, 537 3, 981 1, 589, 784 209, 003 3, 658, 381 799, 655	192. 00 192. 01 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05
194. 06 07956 RENTAL PROPERTIES 194. 07 07957 SNF NON CERTIFIED	0	183, 812 3, 920, 795	0	183, 812 3, 920, 795	194. 06 194. 07
200.00 Cross Foot Adjustments		3, 720, 195 0	0	3, 920, 195 0	200.00
201.00 Negative Cost Centers	o o	0	Ö	Ö	201.00
202.00 TOTAL (sum lines 118 through 201)	414, 739	348, 970, 010	О	348, 970, 010	202. 00

| Period: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0005

				Ť.	o 12/31/2021		
			CAPI TAL			5/26/2022 12:	56 piii
			RELATED COSTS				
	Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMINISTRATIV	
		Assigned New	FLXT		BENEFITS	E & GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs 0	1.00	2A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	I ZA	4.00	5.00	
	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	359, 378	359, 378	359, 378		4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	1, 966, 593	1, 966, 593	32, 884	1, 999, 477	5.00
	00700 OPERATION OF PLANT	0	3, 735, 230	3, 735, 230	5, 889	115, 153	7. 00
	00800 LAUNDRY & LINEN SERVICE	0	307, 825				8. 00
	00900 HOUSEKEEPI NG	0	144, 366				9.00
	01000 DI ETARY 01100 CAFETERI A	0	542, 125				1
	01300 NURSING ADMINISTRATION	0	96, 276 280, 221	280, 221	2, 990 10, 416		11. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY	0	523, 322				14.00
	01500 PHARMACY	0	221, 258			28, 930	15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	175, 660				16.00
	01700 SOCIAL SERVICE	0	30, 291	30, 291	4, 164	17, 015	17.00
23. 00	02300 PARAMED ED PRGM-EMS	0	64, 659	64, 659	240	1, 554	23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	1 0	0.445.545	0.4/5.545	04 745	447.007	
	03000 ADULTS & PEDIATRICS	0	_,,				30.00
	03100 INTENSIVE CARE UNIT 04300 NURSERY	0 0				l .	31.00 43.00
	04400 SKILLED NURSING FACILITY	0					44.00
	ANCILLARY SERVICE COST CENTERS				0		11.00
	05000 OPERATING ROOM	0	726, 878	726, 878	5, 815	113, 454	50.00
	05001 ENDOSCOPY	0	503, 096	503, 096	2, 346	12, 928	50. 01
	05100 RECOVERY ROOM	0	887, 069			l .	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	355, 429			26, 434	52.00
	05300 ANESTHESI OLOGY	0	0		15, 629	l .	53.00
	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI ATI ON-ONCOLOGY	0	1, 110, 139 414, 360			69, 406 20, 179	54. 00 54. 01
	05600 RADI OI SOTOPE	0	1 414, 360		1, 869		56.00
	05601 NUCLEAR MEDICINE	0	17, 055		-	1	56. 01
	05900 CARDI AC CATHETERI ZATI ON	0	308, 505			1	59.00
	06000 LABORATORY	0	462, 774			75, 553	60.00
	06400 I NTRAVENOUS THERAPY	0	227, 180			12, 718	64.00
	06500 RESPI RATORY THERAPY	0	370, 834			30, 948	65.00
	06600 PHYSI CAL THERAPY	0	791, 310			64, 345	66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	232, 714				67. 00 68. 00
	06900 ELECTROCARDI OLOGY		76, 859 135, 466				•
	06901 CARDI AC REHAB	0	158, 573			l	1
	07000 ELECTROENCEPHALOGRAPHY	0	86, 794				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	72, 692	
	07300 DRUGS CHARGED TO PATIENTS	0	0				1
	07301 ULTRA SOUND	0			1, 227	4, 950	1
	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0	0	1	3, 169	74.00
	09000 CLINIC	0	660, 795	660, 795	3, 303	37, 355	90.00
	09100 EMERGENCY						ł
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1	1, 223, 222	0			92.00
	SPECIAL PURPOSE COST CENTERS						
118. 00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	0	19, 858, 261	19, 858, 261	231, 542	1, 319, 169	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CLANS' PRI VATE OFFI CES	0					1
	19201 HEALTH TRACKS	0					1
	07950 PRIMARY CARE CLINIC 07951 PARTNERS IN CARE		361, 902 0		3, 024 0		194. 00 194. 01
	07951 PARTNERS TN CARE 07952 OCCUPATIONAL MEDICINE		140, 741	140, 741	1, 114	l	194. 01
	07953 FOUNDATION	0	25, 080				194. 02
	07954 SCHOOL & TOWN CLINICS	0	37, 151		4, 044		
	07955 MANAGED FACILITY	0	0		894		194. 05
	07956 RENTAL PROPERTIES	0	60, 193				194. 06
	07957 SNF NON CERTIFIED	0	427, 823		2, 676	14, 386	
200.00	,		_	0		_	200.00
201. 00 202. 00		0	0 27, 914, 532				201.00
202.00	TOTAL (Suill TITIES TTO LITTUUGIT 201)	1	21, 714, 332	21, 714, 332	307, 3/8	1, 777, 4//	202.00

Provider CCN: 15-0005

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared:

			To	12/31/2021	Date/Time Pre 5/26/2022 12:	pared:
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	36 pili
,	PLANT	LINEN SERVICE				
OFNEDAL CERVICOS COCT CENTERS	7. 00	8. 00	9. 00	10.00	11. 00	
1.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					I	4.00
5. 00 00500 ADMINI STRATI VE & GENERAL					I	5.00
7.00 00700 OPERATION OF PLANT	3, 856, 272				I	7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	311, 212			1	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	50, 252 197, 147	0		752, 706		9. 00 10. 00
11. 00 01100 CAFETERI A	35, 012	Ö		732, 700	151, 926	1
13.00 01300 NURSING ADMINISTRATION	101, 904	0	1	o	7, 876	1
14.00 01400 CENTRAL SERVICES & SUPPLY	182, 331	0		0	3, 784	1
15. 00 01500 PHARMACY	80, 462	349	1	0	5, 074	1
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	63, 880 0	0	_	0	1, 570 4, 111	1
23. 00 02300 PARAMED ED PRGM-EMS	23, 514	0	1	0		
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 03000 ADULTS & PEDIATRICS	828, 192			517, 382	23, 494	
31. 00 03100 INTENSIVE CARE UNIT	103, 693			97, 060		1
43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY	19, 630 0		1	70, 392 0	3, 267 0	1
ANCILLARY SERVICE COST CENTERS			1 0	<u> </u>	0	44.00
50. 00 05000 OPERATING ROOM	264, 334	10, 385	9, 540	0	6, 250	50.00
50. 01 05001 ENDOSCOPY	182, 954	15, 495		0	,	1
51. 00 05100 RECOVERY ROOM	322, 589			0	3, 155	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	129, 254 0	13, 055 0		0	5, 879	1
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	204, 785	Ĭ		0	4, 115 13, 337	1
54. 01 05401 RADI ATI ON-ONCOLOGY	0	2, 499		o	2, 082	1
56. 00 05600 RADI 0I SOTOPE	0	0	0	О	0	56.00
56. 01 05601 NUCLEAR MEDICINE	6, 202	0		0	546	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	112, 190	ł	_, _,	0	1, 410	1
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	129, 772 39, 154	3, 218 25	1	0	10, 685 2, 738	1
65. 00 06500 RESPIRATORY THERAPY	120, 722	0		o	5, 376	1
66. 00 06600 PHYSI CAL THERAPY	89, 971	17, 206	1	ō	15, 112	1
67. 00 06700 OCCUPATI ONAL THERAPY	5, 096	ł		o	1, 095	1
68. 00 06800 SPEECH PATHOLOGY	27, 950	ł	784	0	696	1
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	49, 263 34, 788	4, 810 44	1	0	3, 075 1, 541	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	31, 563	319		0	234	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		Ö	0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	O	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
73. 01 07301 ULTRA SOUND 74. 00 07400 RENAL DI ALYSI S	8, 026 0	l e		0	1, 119 1	1
OUTPATIENT SERVICE COST CENTERS	0	40	523	U		74.00
90. 00 09000 CLINIC	0	12, 785	9, 933	0	0	90.00
91. 00 09100 EMERGENCY	242, 621	48, 719	21, 172	o	13, 263	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS	2 407 251	200 5/1	100.040	404 024	149, 283	110 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	3, 687, 251	289, 561	188, 849	684, 834	149, 283]118.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	13, 440	11, 266	28, 621	O	0	192. 00
192.01 19201 HEALTH TRACKS	0	2, 213	1	О		192. 01
194.00 07950 PRIMARY CARE CLINIC	0	1, 611	1	0		194. 00
194. 01 07951 PARTNERS IN CARE	0	0	0	0		194. 01
194. 02 07952 0CCUPATI ONAL MEDICINE 194. 03 07953 FOUNDATI ON	0		2, 745 131	0		194. 02 194. 03
194.04 07954 SCHOOL & TOWN CLINICS	0	· -	1	ol Ol		194. 03
194. 05 07955 MANAGED FACILITY	0	0	0	o		194. 05
194. 06 07956 RENTAL PROPERTIES	0	0	0	o		194. 06
194. 07 07957 SNF NON CERTIFIED	155, 581	6, 062	0	67, 872	2, 643	194. 07
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	_		0		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	3, 856, 272	1	230, 408	752, 706		
(22		,		, . 00	, .20	

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0005

			To	12/31/2021	Date/Time Pre 5/26/2022 12:	
Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	<u> Б.ш.</u>
	13. 00	14. 00	15.00	16. 00	17. 00	
GENERAL SERVICE COST CENTERS 1.00 OO100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
13. 00 O1300 NURSI NG ADMI NI STRATI ON 14. 00 O1400 CENTRAL SERVI CES & SUPPLY	455, 355 0	707 700				13.00
14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY	0	727, 722 0	342, 668			14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	Ö	Ö	0	252, 610		16.00
17. 00 01700 SOCI AL SERVI CE	0	0	0	0	55, 712	
23. 00 02300 PARAMED ED PRGM-EMS	0	0	0	0	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	111, 730	ol	0	18, 694	27, 640	30.00
31. 00 03100 I NTENSI VE CARE UNI T	22, 888	Ö	Ö	6, 951	5, 184	1
43. 00 04300 NURSERY	15, 537	О	0	4, 730	0	43.00
44. 00 O4400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	29, 720	727, 722	0	48, 392	17, 176	50.00
50. 01 05001 ENDOSCOPY	10, 967	0	0	8, 301	0	50. 01
51. 00 05100 RECOVERY ROOM	15, 006	0	0	7, 907	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESIOLOGY	27, 958	0	0	8, 512	0	52. 00 53. 00
54. 00 05400 RADI OLOGY 54. 00 05400 RADI OLOGY DI AGNOSTI C	19, 571 63, 423	0	0	8, 358	0	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0	Ö	0	14, 364	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	56.00
56. 01 05601 NUCLEAR MEDICINE	2, 596	0	0	0	0	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	6, 705 0	0	0	20, 289 39, 709	0	59. 00 60. 00
64. 00 06400 I NTRAVENOUS THERAPY	Ö	Ö	0	0,7,07	0	64.00
65. 00 06500 RESPI RATORY THERAPY	25, 568	0	0	11, 047	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	6, 303 1, 051	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	682	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	14, 626	Ō	0	5, 614	0	69.00
69. 01 06901 CARDI AC REHAB	7, 330	0	0	643	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00 71.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	Ö	Ö	342, 668	Ö	0	73.00
73. 01 07301 ULTRA SOUND	0	0	0	0	0	73. 01
74.00 O7400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	3	0	0	178	0	74.00
90. 00 09000 CLINIC	0	ol	0	ol	0	90.00
91. 00 09100 EMERGENCY	69, 157	O	0	40, 885	5, 712	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	442, 785	727, 722	342, 668	252, 610	55 712	118. 00
NONREIMBURSABLE COST CENTERS	442, 765	121, 122	342,000	232, 010	55, 712	1110.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
192. 01 19201 HEALTH TRACKS	0	0	0	0		192. 01
194. 00 07950 PRIMARY CARE CLINIC 194. 01 07951 PARTNERS IN CARE	0	0	0	0		194. 00 194. 01
194. 02 07952 OCCUPATI ONAL MEDICINE	o	ő	0	o		194. 02
194. 03 07953 FOUNDATI ON	0	O	0	o		194. 03
194.04 07954 SCHOOL & TOWN CLINICS	0	0	0	0		194.04
194. 05 07955 MANAGED FACILITY 194. 06 07956 RENTAL PROPERTIES	0	0	0	0		194. 05 194. 06
194.07 07957 SNF NON CERTIFIED	12, 570	ő	Ö	Ö		194. 07
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	455, 355	727, 722	342, 668	252, 610	55, 712	1202.00

Health Financial Systems	HENDRICKS REGIO	ONAL HEALTH		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/26/2022 12:56 pm
Cost Center Description	PARAMED ED PRGM-EMS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	23. 00	24. 00	25. 00	26.00	
GENERAL SERVICE COST CENTERS					
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE 23. 00 02300 PARAMED ED PRGM-EMS INPATIENT ROUTINE SERVICE COST CENTERS	91, 246				1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 23. 00
30. 00 03000 ADULTS & PEDI ATRI CS		4, 252, 251	0	4, 252, 251	30.00
31.00 03100 INTENSIVE CARE UNIT 43.00 04300 NURSERY 44.00 04400 SKI LLED NURSING FACILITY ANCI LLARY SERVICE COST CENTERS		595, 996 192, 247 0	0	595, 996 192, 247 0	31.00 43.00 44.00
50. 00 05000 OPERATING ROOM		1, 959, 666	0	1, 959, 666	50.00
50. 01 05001 ENDOSCOPY 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 01 05401 RADI OLOGY-DI AGNOSTI C 54. 01 05401 RADI ATI ON-ONCOLOGY 56. 00 05600 RADI OI SOTOPE 56. 01 05601 NUCLEAR MEDI CI NE 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06400 LABORATORY 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 01 06901 CARDI AC REHAB		743, 359 1, 285, 657 578, 813 46, 181 1, 536, 054 459, 404 0 31, 565 462, 290 740, 305 286, 722 571, 929 1, 020, 147 248, 916 111, 157 226, 491 214, 611	0 0 0 0 0 0 0 0 0	743, 359 1, 285, 657 578, 813 46, 181 1, 536, 054 459, 404 0 31, 565 462, 290 740, 305 286, 722 571, 929 1, 020, 147 248, 916 111, 157 226, 491 214, 611	50. 01 51. 00 52. 00 53. 00 54. 00 54. 01 56. 00 56. 01 59. 00 60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		122, 249	0	122, 249	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 73. 00 07300 DRUGS CHARGED TO PATIENTS 73. 01 07301 ULTRA SOUND 74. 00 07400 RENAL DI ALYSIS		72, 692 523, 395 37, 785 3, 921	0 0 0 0	72, 692 523, 395 37, 785 3, 921	71.00 72.00 73.00 73.01 74.00
90. 00 09000 CLI NI C		724, 171	0	724, 171	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS		1, 595, 581	0	1, 595, 581	91. 00 92. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	0	18, 643, 555	0	18, 643, 555	118. 00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 HEALTH TRACKS		7, 307, 478 481, 172	0	7, 307, 478 481, 172	192. 00 192. 01
194. 00 07950 PRIMARY CARE CLINIC 194. 01 07951 PARTNERS IN CARE 194. 02 07952 OCCUPATI ONAL MEDICINE 194. 03 07953 FOUNDATI ON 194. 04 07954 SCHOOL & TOWN CLINICS 194. 05 07955 MANAGED FACILITY 194. 06 07956 RENTAL PROPERTIES 194. 07 07957 SNF NON CERTIFIED	01.04	391, 866 23 153, 683 26, 642 62, 532 5, 476 61, 246 689, 613		391, 866 23 153, 683 26, 642 62, 532 5, 476 61, 246 689, 613	194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	91, 246	91, 246 0	0	91, 246 0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	91, 246	27, 914, 532		27, 914, 532	

COST ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2021	Worksheet B-1	
				o 12/31/2021	Date/Time Pre	
	CADLTAL				5/26/2022 12:	56 pm
	CAPI TAL RELATED COSTS					
Cost Center Description	NEW BLDG &	EMPLOYEE	 Reconciliatio	ADMI NI STRATI V	OPERATION OF	
· ·	FLXT	BENEFI TS	n	E & GENERAL	PLANT	
	(SQUARE FEE)	DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
		(GROSS				
	1. 00	SALARI ES) 4. 00	5A	5. 00	7. 00	
GENERAL SERVICE COST CENTERS	1.00	4.00	J 3/1	3.00	7.00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT	862, 577					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	11, 105	171, 546, 908	1			4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	60, 769	15, 696, 235	1		ł	5.00
7. 00 00700 0PERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	115, 421	2, 810, 945	i	,,		1
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	9, 512 4, 461	351, 270 2, 986, 944	1	,	4, 270	1
10. 00 01000 DI ETARY	16, 752	593, 272	1		l '	1
11. 00 01100 CAFETERI A	2, 975	1, 427, 409	l .		l '	1
13.00 01300 NURSING ADMINISTRATION	8, 659	4, 971, 869	C	8, 134, 716	8, 659	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	16, 171	1, 149, 527	l .		1	1
15. 00 01500 PHARMACY	6, 837	2, 773, 576	ı	.,,		1
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	5, 428 936	501, 426 1, 987, 386	l .			1
23. 00 02300 PARAMED ED PRGM-EMS	1, 998	114, 743				
INPATIENT ROUTINE SERVICE COST CENTERS	1,770	111,710		2007.00	1,770	20.00
30. 00 03000 ADULTS & PEDIATRICS	76, 186	15, 138, 512	C	17, 552, 878	70, 373	30.00
31.00 03100 INTENSIVE CARE UNIT	8, 811	2, 877, 433	1			
43. 00 04300 NURSERY	1, 668	1, 527, 099			1, 668	1
44.00 O4400 SKILLED NURSING FACILITY	0	0	<u> </u>	0	0	44.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	22, 461	2, 775, 624		17, 166, 542	22, 461	50.00
50. 01 05001 ENDOSCOPY	15, 546	1, 119, 634	1		15, 546	
51. 00 05100 RECOVERY ROOM	27, 411	1, 681, 118	1		1	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	10, 983	2, 747, 911	c	3, 999, 660	10, 983	
53. 00 05300 ANESTHESI OLOGY	0	7, 459, 926	1		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	34, 304	6, 547, 728	1			
54. 01 05401 RADI ATI ON-ONCOLOGY 56. 00 05600 RADI OI SOTOPE	12, 804	892, 252	C		0 1 0	
56. 01 05601 NUCLEAR MEDICINE	527	280, 718	_	_	527	
59. 00 05900 CARDI AC CATHETERI ZATI ON	9, 533	668, 256	1		l e	1
60. 00 06000 LABORATORY	14, 300	3, 697, 748	1		l '	1
64.00 06400 I NTRAVENOUS THERAPY	7, 020	1, 468, 609	l .		l '	1
65. 00 06500 RESPIRATORY THERAPY	11, 459	2, 674, 730		.,	10, 258	1
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	24, 452	6, 905, 705	l .	.,,	1	1
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	7, 191 2, 375	542, 743 354, 985	l .		l	1
69. 00 06900 ELECTROCARDI OLOGY	4, 186	991, 139			1	1
69. 01 06901 CARDI AC REHAB	4, 900	724, 317	l .			1
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 682	90, 737	C	199, 635	2, 682	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1		"	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C		0	1
73.00 07300 DRUGS CHARGED TO PATIENTS 73.01 07301 ULTRA SOUND	0 682	585, 608	C		0 682	
74. 00 07400 RENAL DIALYSIS	002	308	1			1
OUTPATIENT SERVICE COST CENTERS	<u> </u>		1 ~	1777 100		1
90. 00 09000 CLI NI C	20, 419	1, 576, 692	C	5, 652, 170	0	90.00
91. 00 09100 EMERGENCY	32, 709	11, 827, 428	C	10, 705, 458	20, 616	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	412 422	110 E21 E42	14 114 027	100 401 020	212 212	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	613, 633	110, 521, 562	-46, 446, 837	199, 601, 929	313, 313]118.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	203, 074	51, 922, 397	1 0	86, 767, 593	1. 142	192.00
192. 01 19201 HEALTH TRACKS	13, 335	3, 373, 091	1			192. 01
194.00 07950 PRIMARY CARE CLINIC	11, 183	1, 443, 563		3, 219, 592	0	194.00
194. 01 07951 PARTNERS IN CARE	0	0	C	-,		194. 01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	4, 349	531, 514		.,,		194. 02 194. 03
194.03 07953 FOUNDATION 194.04 07954 SCHOOL & TOWN CLINICS	775 1, 148	119, 986 1, 930, 394		,		194. 03
194.05 07955 MANAGED FACILITY	1, 148	426, 923		693, 223		194. 04
194. 06 07956 RENTAL PROPERTIES	1, 860	0	ď		0	194.06
194.07 07957 SNF NON CERTIFIED	13, 220	1, 277, 478	c			
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	27 044 500	07 /04 003		4/ 44/ 007	20, 000, 770	201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	27, 914, 532	27, 634, 224		46, 446, 837	20, 098, 770	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	32. 361786	0. 161088		0. 153532	61. 337514	203 00
204.00 Cost to be allocated (per Wkst. B,	32. 331,30	359, 378	l .	1, 999, 477	3, 856, 272	
Part II)						
	<u> </u>					

Health Financial Systems	HENDRICKS REGIONAL HEALTH			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der C	Provi der CCN: 15-0005		Worksheet B-1		
				To 12/31/2021	Date/Time Pre 5/26/2022 12:		
Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliati n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	PLANT		
	1. 00	4.00	5A	5. 00	7. 00		
205.00 Unit cost multiplier (Wkst. B, Part		0. 002095		0. 006609	11. 768588	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	

COST ALL	OCATION - STATISTICAL BASIS		Provi der CC	N: 15-0005 Pe	eriod: rom 01/01/2021	Worksheet B-1	
				To		Date/Time Pre	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	5/26/2022 12: NURSI NG	56 pm
	·	LINEN SERVICE	(HOURS OF	(PATI ENT	(MANHOURS)	ADMI NI STRATI O	
		(POUNDS OF LAUNDRY)	SERVI CE)	DAYS)		N (DI RECT	
		,				NRŜI NG HRS)	
GE	NERAL SERVICE COST CENTERS	8. 00	9. 00	10. 00	11. 00	13. 00	
	0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT						5. 00 7. 00
1	D800 LAUNDRY & LINEN SERVICE	975, 362					8.00
	1900 HOUSEKEEPI NG	0	1, 763	25 005			9.00
	000 DI ETARY 100 CAFETERI A		39	25, 995 0	1, 872, 990		10.00
13. 00 01	300 NURSING ADMINISTRATION	0	9	0	97, 095	1, 180, 451	1
	400 CENTRAL SERVICES & SUPPLY	0	3	0	46, 647	0	
	500 PHARMACY 600 MEDICAL RECORDS & LIBRARY	1, 094	0	0	62, 550 19, 356	0	15. 00 16. 00
	700 SOCIAL SERVICE	0	1	0	50, 682	0	17. 00
	2300 PARAMED ED PRGM-EMS	0	0	0	15, 772	0	23.00
	IPATIENT ROUTINE SERVICE COST CENTERS BOOO ADULTS & PEDIATRICS	228, 177	299	17, 868	289, 644	289, 644	30.00
	100 INTENSIVE CARE UNIT	67, 371	107	3, 352	59, 335	59, 335	
	300 NURSERY	22, 736	4	2, 431	40, 277	40, 277	1
	400 SKILLED NURSING FACILITY CILLARY SERVICE COST CENTERS	0	0	0	0	0	44.00
	0000 OPERATING ROOM	32, 547	73	0	77, 046	77, 046	50.00
	5001 ENDOSCOPY	48, 562	38	0	28, 431	28, 431	1
	6100 RECOVERY ROOM 6200 DELIVERY ROOM & LABOR ROOM	68, 464 40, 915	36 50	0	38, 900 72, 478	38, 900 72, 478	1
	3300 ANESTHESI OLOGY	0	2	0	50, 736	50, 736	1
	6400 RADI OLOGY-DI AGNOSTI C	116, 605	120	0	164, 417	164, 417	1
	6401 RADI ATI ON-ONCOLOGY 6600 RADI OI SOTOPE	7, 833	31 0	0	25, 672 0	0	54. 01 56. 00
1	6601 NUCLEAR MEDICINE	o o	3	0	6, 731	6, 731	1
	5900 CARDI AC CATHETERI ZATI ON	0	20	0	17, 383	17, 383	1
1	000 LABORATORY 0400 INTRAVENOUS THERAPY	10, 086 78	83 14	0	131, 726 33, 755	0	60.00
1	5500 RESPIRATORY THERAPY	0	14	0	66, 281	66, 281	1
	6600 PHYSI CAL THERAPY	53, 924	164	0	186, 304	0	
	5700 OCCUPATIONAL THERAPY 5800 SPEECH PATHOLOGY	0	15 6	0	13, 494 8, 575	0	67. 00 68. 00
	9900 ELECTROCARDI OLOGY	15, 074	16	0	37, 915	37, 915	1
1	9901 CARDI AC REHAB	139	24	0	19, 003	19, 003	•
	OOO ELECTROENCEPHALOGRAPHY OO MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 001	14	0	2, 884 0	0	
1	200 IMPL. DEV. CHARGED TO PATIENT	o o	Ö	0	Ö	0	1
	300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	/301 ULTRA SOUND /400 RENAL DIALYSIS	0 144	3	0	13, 799 7	0	73. 01 74. 00
	ITPATIENT SERVICE COST CENTERS				, ,	,	7 1. 00
	2000 CLINIC	40, 068	76	0	0	0	
	2100 EMERGENCY 2200 OBSERVATION BEDS (NON-DISTINCT PART)	152, 688	162	0	163, 508	179, 280	91.00
	PECIAL PURPOSE COST CENTERS						72.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	907, 506	1, 445	23, 651	1, 840, 403	1, 147, 864	118.00
	NREIMBURSABLE COST CENTERS P200 PHYSICIANS' PRIVATE OFFICES	35, 309	219	0	0	0	192. 00
192. 01 19	201 HEALTH TRACKS	6, 935	44	0	0	0	192. 01
	7950 PRIMARY CARE CLINIC 7951 PARTNERS IN CARE	5, 048	31	0	0		194.00
	7952 OCCUPATIONAL MEDICINE	1, 087	0 21	0	0		194. 01 194. 02
194. 03 07	7953 FOUNDATI ON	0	1	0	0	0	194. 03
	7954 SCHOOL & TOWN CLINICS	477	2	0	0		194. 04 194. 05
	7955 MANAGED FACILITY 1956 RENTAL PROPERTIES	0 0	0	0	0		194. 05
194. 07 07	957 SNF NON CERTIFIED	19, 000	0	2, 344	32, 587		194. 07
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	462, 654	5, 416, 447	2, 977, 723	2, 492, 901	10, 071, 659	
	Part I)						
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 474341 311, 212	3, 072. 289847 230, 408	114. 549837 752, 706	1. 330974 151, 926	8. 532043 455, 355	
204.00	Part II)	311, 212	230, 408	152, 100	101, 920	400, 305	204.00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 319073	130. 690868	28. 955799	0. 081114	0. 385747	205. 00
	11)		l		l		<u> </u>

Heal th Finar	ncial Systems	HENDRI CKS REG	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C	CN: 15-0005	Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 12:	
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERI A (MANHOURS)	NURSI NG ADMI NI STRATI O N	
		LAUNDRY)	ŕ	ŕ		(DI RECT NRSI NG HRS)	
		8. 00	9. 00	10.00	11. 00	13.00	
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

37, 243. 790000 55, 710. 040000

342, 668

3, 426, 680000

727, 722

7, 277. 220000

0.004012

0.000464

252, 610

101. 083283

55, 712

1.852251

4, 147. 390000 203. 00

912. 460000 205. 00

91, 246 204.00

203.00

204.00

205.00

Part I)

Part II)

II)

Unit cost multiplier (Wkst. B, Part I)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Health Financial S	Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION -	STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 12:	
Cost (Center Description	CENTRAL SERVI CES & SUPPLY (100% ALLOCATI ON)	PHARMACY (100% ALLOCATION)	MEDI CAL RECORDS & LI BRARY (C)	SOCI AL SERVI CE (TI ME SPENT)	PARAMED ED PRGM-EMS (ASSIGNED TIME)	
		14. 00	15. 00	16.00	17. 00	23.00	
	adjustment amount to be allocated Wkst. B-2)					0	206. 00
207. 00 NAHE (unit cost [°] multiplier (Wkst. D, III and IV)					0. 000000	207. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Peri od: Worksheet C From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

					To 12/31/2021	Date/Time Pre 5/26/2022 12:	pared: 56 pm
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	•				
		col. 26)					
		1. 00	2. 00	3.00	4.00	5. 00	
1.1	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03	3000 ADULTS & PEDIATRICS	32, 164, 699		32, 164, 69	9 0	32, 164, 699	30.00
31.00 0	3100 INTENSIVE CARE UNIT	7, 233, 004		7, 233, 00	04		
43.00 04	4300 NURSERY	3, 239, 516		3, 239, 51	6 0	3, 239, 516	43.00
44.00 04	4400 SKILLED NURSING FACILITY	0			0 0	0	44.00
1A	NCILLARY SERVICE COST CENTERS	· ·					1
50.00 0!	5000 OPERATING ROOM	27, 258, 067		27, 258, 06	07	27, 258, 067	50.00
50. 01 0!	5001 ENDOSCOPY	3, 701, 913		3, 701, 91	3 0	3, 701, 913	50. 01
51.00 0	5100 RECOVERY ROOM	5, 742, 548		5, 742, 54	8	5, 742, 548	51.00
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	6, 248, 875		6, 248, 87	75 0		
53. 00 0!	5300 ANESTHESI OLOGY	1, 659, 472		1, 659, 47		1, 659, 472	53.00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	15, 299, 267		15, 299, 26	0 0	15, 299, 267	54.00
54. 01 0!	5401 RADI ATI ON-ONCOLOGY	3, 779, 403		3, 779, 40		3, 779, 403	
56. 00 0!	5600 RADI OI SOTOPE	0			0 0		56.00
56. 01 0!	5601 NUCLEAR MEDICINE	838, 509		838, 50	0	838, 509	56. 01
59. 00 0!	5900 CARDI AC CATHETERI ZATI ON	2, 594, 849		2, 594, 84	9 0	2, 594, 849	59.00
	6000 LABORATORY	14, 641, 832		14, 641, 83	32 0	14, 641, 832	60.00
64.00 0	6400 INTRAVENOUS THERAPY	2, 511, 785		2, 511, 78	85 0	2, 511, 785	64.00
65. 00 0	6500 RESPI RATORY THERAPY	6, 823, 042	0				
	6600 PHYSI CAL THERAPY	12, 531, 565	0				
	6700 OCCUPATI ONAL THERAPY	1, 122, 995	0	1, 122, 99		1, 122, 995	
68.00 0	6800 SPEECH PATHOLOGY	782, 257	0	782, 25			1
	6900 ELECTROCARDI OLOGY	2, 388, 405		2, 388, 40			
	6901 CARDI AC REHAB	1, 676, 526		1, 676, 52			
	7000 ELECTROENCEPHALOGRAPHY	442, 118		442, 11			
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0		71.00
	7200 I MPL. DEV. CHARGED TO PATIENT	12, 687, 584		12, 687, 58	-	1	
	7300 DRUGS CHARGED TO PATIENTS	37, 115, 089		37, 115, 08			
	7301 ULTRA SOUND	933, 413		933, 41			
	7400 RENAL DIALYSIS	566, 999		566, 99			1
	UTPATIENT SERVICE COST CENTERS	000, 777		000,77	71 0	000,777	7 1. 00
	9000 CLINIC	6, 772, 459		6, 772, 45	i9 0	6, 772, 459	90.00
	9100 EMERGENCY	17, 011, 004		17, 011, 00			
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 044, 128		6, 044, 12		6, 044, 128	
200.00	Subtotal (see instructions)	233, 811, 323	0				
201.00	Less Observation Beds	6, 044, 128	Ü	6, 044, 12		6, 044, 128	
202.00	Total (see instructions)	227, 767, 195	0				
202.00	1.014. (300 111311 4011 0113)	227, 707, 179	O	22,,,07,17	0	227, 107, 179	1-32.00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-	
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Peri od: From 01/01/2021	Worksheet C Part I

				rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre 5/26/2022 12:	
		Title	XVIII	Hospi tal	PPS	50 piii
		Charges				
Cost Center Description	I npati ent	Outpati ent	+ col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	34, 793, 393		34, 793, 393			30.00
31.00 03100 INTENSIVE CARE UNIT	13, 964, 114		13, 964, 114			31.00
43. 00 04300 NURSERY	10, 197, 663		10, 197, 663			43.00
44.00 O4400 SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	22, 020, 850	72, 057, 134				50.00
50. 01 05001 ENDOSCOPY	1, 204, 700	16, 248, 274		0. 212108	0. 000000	50. 01
51.00 05100 RECOVERY ROOM	1, 987, 939	15, 052, 167			0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	18, 343, 957	489, 525			0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	4, 739, 541	19, 497, 408			0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 139, 710	83, 798, 313			0. 000000	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	200, 329	29, 880, 164	30, 080, 493		0.000000	54.01
56. 00 05600 RADI 0I SOTOPE	0	0	0	0.00000	0.000000	56.00
56. 01 05601 NUCLEAR MEDICINE	646, 385	8, 599, 026		0. 090695	0.000000	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	12, 700, 832	24, 039, 352			0.000000	59.00
60. 00 06000 LABORATORY	21, 959, 925	75, 962, 944			0.000000	60.00
64.00 06400 I NTRAVENOUS THERAPY	199, 827	25, 529, 796			0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	14, 834, 288	9, 862, 732			0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 952, 597	23, 449, 314			0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 171, 662	2, 077, 092			0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	525, 447	1, 596, 026			0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	5, 594, 145	18, 653, 177			0. 000000	69. 00
69. 01 06901 CARDI AC REHAB	22, 884	2, 746, 419			0. 000000	69. 01
70.00 07000 ELECTROENCEPHALOGRAPHY	278, 742	721, 484	1, 000, 226		0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	_	0.00000	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	7, 240, 596	20, 697, 567			0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	26, 967, 675	96, 068, 152			0.000000	73.00
73. 01 07301 ULTRA SOUND	2, 563, 512	10, 317, 175	12, 880, 687	0. 072466	0.000000	73. 01
74. 00 07400 RENAL DIALYSIS	328, 278	54, 447	382, 725	1. 481479	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	22, 833	39, 078, 537			0. 000000	90.00
91. 00 09100 EMERGENCY	20, 547, 914	98, 534, 887			0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	853, 380	4, 288, 511			0. 000000	
200.00 Subtotal (see instructions)	238, 003, 118	699, 299, 623	937, 302, 741			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	238, 003, 118	699, 299, 623	937, 302, 741			202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared:

			10 12/31/2021	Date/IIMe Prepared 5/26/2022 12:56 pm	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				30.0	
31.00 03100 INTENSIVE CARE UNIT				31.0	
43. 00 04300 NURSERY				43.0	
44.00 O4400 SKILLED NURSING FACILITY				44.0	00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 289739			50.0	
50. 01 05001 ENDOSCOPY	0. 212108			50.0	
51. 00 05100 RECOVERY ROOM	0. 337002			51.0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 331796			52.0	
53. 00 05300 ANESTHESI OLOGY	0. 068469			53.0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 159470			54.0	
54. 01 05401 RADI ATI ON-ONCOLOGY	0. 125643			54.0	
56. 00 05600 RADI OI SOTOPE	0. 000000			56.0	
56. 01 05601 NUCLEAR MEDICINE	0. 090695			56.0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 070627			59.0	
60. 00 06000 LABORATORY	0. 149524			60.0	
64.00 06400 I NTRAVENOUS THERAPY	0. 097622			64.0	
65. 00 06500 RESPI RATORY THERAPY	0. 276270			65.0	
66. 00 06600 PHYSI CAL THERAPY	0. 493332			66.0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 345669			67.0	
68. 00 06800 SPEECH PATHOLOGY	0. 368733			68.0	
69. 00 06900 ELECTROCARDI OLOGY	0. 098502			69.0	
69. 01 06901 CARDI AC REHAB	0. 605396			69.0	
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 442018			70.0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 454131			72.0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 301661			73.0	
73.01 07301 ULTRA SOUND	0. 072466			73.0	
74. 00 07400 RENAL DIALYSIS	1. 481479			74.0	00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 173203			90.0	
91. 00 09100 EMERGENCY	0. 142850			91.0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 175468			92.0	
200.00 Subtotal (see instructions)				200.0	
201.00 Less Observation Beds				201. (
202.00 Total (see instructions)				202.0	00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Period: Worksheet C From 01/01/2021 Part I
		To 12/31/2021 Date/Time Prepared

					To 12/31/2021	Date/Time Pre 5/26/2022 12:	pared: 56 pm
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	TENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	32, 164, 699		32, 164, 69	9 0	32, 164, 699	30.00
31.00 03100	INTENSIVE CARE UNIT	7, 233, 004		7, 233, 00	0	7, 233, 004	31.00
43.00 04300	NURSERY	3, 239, 516		3, 239, 51	6 0	3, 239, 516	43.00
44.00 04400	SKILLED NURSING FACILITY	0			0 0	0	44.00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	27, 258, 067		27, 258, 06	7 0	27, 258, 067	50.00
50. 01 05001	ENDOSCOPY	3, 701, 913		3, 701, 91	3 0	3, 701, 913	50. 01
51.00 05100	RECOVERY ROOM	5, 742, 548		5, 742, 54	8 0	5, 742, 548	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	6, 248, 875		6, 248, 87	5 0	6, 248, 875	52.00
53.00 05300	ANESTHESI OLOGY	1, 659, 472		1, 659, 47	2 0	1, 659, 472	53.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	15, 299, 267		15, 299, 26	7 0	15, 299, 267	54.00
54. 01 05401	RADI ATI ON-ONCOLOGY	3, 779, 403		3, 779, 40	3 0	3, 779, 403	54. 01
56.00 05600	RADI OI SOTOPE	O			0 0	0	56.00
56. 01 05601	NUCLEAR MEDICINE	838, 509		838, 50	9 0	838, 509	56. 01
59.00 05900	CARDIAC CATHETERIZATION	2, 594, 849		2, 594, 84	9 0	2, 594, 849	59.00
	LABORATORY	14, 641, 832		14, 641, 83	2 0	14, 641, 832	60.00
64.00 06400	I NTRAVENOUS THERAPY	2, 511, 785		2, 511, 78	5 0	2, 511, 785	64.00
65. 00 06500	RESPI RATORY THERAPY	6, 823, 042	0	1		6, 823, 042	65.00
66. 00 06600	PHYSI CAL THERAPY	12, 531, 565	0	12, 531, 56	5 0	12, 531, 565	66.00
67. 00 06700	OCCUPATI ONAL THERAPY	1, 122, 995	0	1, 122, 99		1, 122, 995	
68. 00 06800	SPEECH PATHOLOGY	782, 257	0	782, 25		782, 257	
69. 00 06900	ELECTROCARDI OLOGY	2, 388, 405		2, 388, 40		2, 388, 405	
69. 01 06901	CARDI AC REHAB	1, 676, 526		1, 676, 52		1, 676, 526	69. 01
70.00 07000	ELECTROENCEPHALOGRAPHY	442, 118		442, 11			
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71.00
	IMPL. DEV. CHARGED TO PATIENT	12, 687, 584		12, 687, 58	4 0	12, 687, 584	72.00
	DRUGS CHARGED TO PATIENTS	37, 115, 089		37, 115, 08			
	ULTRA SOUND	933, 413		933, 41			
	RENAL DIALYSIS	566, 999		566, 99			
	TIENT SERVICE COST CENTERS				-		1
90.00 09000		6, 772, 459		6, 772, 45	9 0	6, 772, 459	90.00
91.00 09100		17, 011, 004		17, 011, 00			1
	OBSERVATION BEDS (NON-DISTINCT PART)	6, 044, 128		6, 044, 12		6, 044, 128	
200.00	Subtotal (see instructions)	233, 811, 323	0				
201. 00	Less Observation Beds	6, 044, 128	· ·	6, 044, 12		6, 044, 128	
202.00	Total (see instructions)	227, 767, 195	0				
I I		1 1			1		•

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Peri od: From 01/01/2021	

				Γο 12/31/2021	Date/Time Pre 5/26/2022 12:	
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	34, 793, 393		34, 793, 393	3		30.00
31.00 03100 INTENSIVE CARE UNIT	13, 964, 114		13, 964, 114	4		31.00
43. 00 04300 NURSERY	10, 197, 663		10, 197, 66	3		43.00
44.00 04400 SKILLED NURSING FACILITY	o			O		44.00
ANCILLARY SERVICE COST CENTERS]
50.00 05000 OPERATING ROOM	22, 020, 850	72, 057, 134	94, 077, 98	0. 289739	0.000000	50.00
50. 01 05001 ENDOSCOPY	1, 204, 700	16, 248, 274	17, 452, 97	0. 212108	0.000000	50. 01
51.00 05100 RECOVERY ROOM	1, 987, 939	15, 052, 167	17, 040, 10	0. 337002	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	18, 343, 957	489, 525	18, 833, 482	0. 331796	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	4, 739, 541	19, 497, 408	24, 236, 94	0. 068469	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 139, 710	83, 798, 313	95, 938, 02	0. 159470	0.000000	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	200, 329	29, 880, 164	30, 080, 49	0. 125643	0.000000	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0		0. 000000	0.000000	56.00
56. 01 05601 NUCLEAR MEDICINE	646, 385	8, 599, 026	9, 245, 41	0. 090695	0.000000	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	12, 700, 832	24, 039, 352	36, 740, 18	0. 070627	0.000000	59.00
60. 00 06000 LABORATORY	21, 959, 925	75, 962, 944	97, 922, 869	0. 149524	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	199, 827	25, 529, 796	25, 729, 62	0. 097622	0.000000	64.00
65. 00 06500 RESPIRATORY THERAPY	14, 834, 288	9, 862, 732	24, 697, 020	0. 276270	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 952, 597	23, 449, 314	25, 401, 91	0. 493332	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 171, 662	2,077,092	3, 248, 75	0. 345669	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	525, 447	1, 596, 026	2, 121, 47	0. 368733	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	5, 594, 145	18, 653, 177	24, 247, 32	0. 098502	0.000000	69.00
69. 01 06901 CARDI AC REHAB	22, 884	2, 746, 419	2, 769, 30	0. 605396	0.000000	69. 01
70.00 07000 ELECTROENCEPHALOGRAPHY	278, 742	721, 484	1, 000, 22	0. 442018	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0. 000000	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	7, 240, 596	20, 697, 567	27, 938, 16	0. 454131	0.000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	26, 967, 675	96, 068, 152	123, 035, 82	0. 301661	0. 000000	73.00
73. 01 07301 ULTRA SOUND	2, 563, 512	10, 317, 175	12, 880, 68	0. 072466	0. 000000	73. 01
74.00 07400 RENAL DIALYSIS	328, 278	54, 447			0. 000000	74.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>					İ
90. 00 09000 CLI NI C	22, 833	39, 078, 537	39, 101, 370	0. 173203	0.000000	90.00
91. 00 09100 EMERGENCY	20, 547, 914	98, 534, 887	119, 082, 80	0. 142850	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	853, 380	4, 288, 511	5, 141, 89 ⁻	1 1. 175468	0. 000000	92.00
200.00 Subtotal (see instructions)	238, 003, 118	699, 299, 623				200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	238, 003, 118	699, 299, 623	937, 302, 74	1		202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/26/2022 12:56 pm

INPATEENT ROUTINE SERVICE COST CENTERS 11.00				To 12/31/2021	Date/Time Prepared: 5/26/2022 12:56 pm
Ratio			Title XIX	Hospi tal	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3300 ADULTS & PEDIATRICS 31.00 3310 INTERSIVE CARE UNIT 43.00 44.00 3410 INTERSIVE COST CENTERS 44.00 3400 INTERSIVE COST CENTERS 44.00 3410 INTERSIVE COST CENTERS	Cost Center Description	PPS Inpatient		<u> </u>	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 30.00 ADULTS & PEDIATRIC S 31.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 44.00 44.00 56.00 56.0		Ratio			
30.00		11. 00			
31.00 03100 INTENSI WE CARE UNIT	INPATIENT ROUTINE SERVICE COST CENTERS				
43.00 04300 NURSERY	30. 00 03000 ADULTS & PEDI ATRI CS				30.00
44. 00 04400 SKI LLED NURSI NG FACILLTY	31.00 03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS	43. 00 04300 NURSERY				43.00
50.00 05000 05000 DERATING ROOM 0.000000 50.01 050001 ENDOSCOPY 0.000000 50.01 050001 ENDOSCOPY 0.000000 50.01 050001 ENDOSCOPY 0.000000 51.00 05000 RECOVERY ROOM 0.000000 55.00 05000 DELI VERY ROOM 0.000000 55.00 05000 DELI VERY ROOM 0.000000 55.00 05000 ARSTHEIS IOLOGY 0.000000 54.01 0.000000 54.01 0.000000 54.01 0.000000 54.01 0.000000 54.01 0.000000 54.01 0.000000 54.01 0.000000 54.01 0.000000 54.01 0.000000 54.01 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000					44.00
50. 01 05001 INDOSCOPY 0.000000 55. 0.0					
51.00					
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 05401 RADI ATI ON-ONCOLOGY 0.000000 54.01 05401 RADI ATI ON-ONCOLOGY 0.000000 54.01 05401 RADI ATI ON-ONCOLOGY 0.000000 54.01 05601 NUCLEAR MEDI CI NE 0.000000 55.00 05500 CARDI IAC CATHETERI ZATI ON 0.0000000 0.00000000					
53. 00 05300 ANESTHESI OLOGY 0.000000 54. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54. 01 05401 RADI ATI ON-ONCOLOGY 0.000000 54. 01 56. 00 05600 RADI OLOGY-DI AGNOSTI C 0.000000 54. 01 56. 00 05600 RADI OLOGY-DI OLOGY 0.000000 56. 00 05600 RADI OLOGY-DI OLOGY 0.000000 56. 00 05600 RADI OLOGY-DI OLOGY 0.000000 0.000000 0.0000 0.0000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	l l	1			
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 54.00 54.01 05401 RADI ATI ON-ONCOLOGY 0.000000 55.00 56.00 05600 RADI OI SOTOPE 0.000000 56.00 56.00 05600 RADI OI SOTOPE 0.000000 56.00 56.01 05601 NUCLEAR MEDI CI NE 0.000000 56.01 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 66.00					l
54. 01 05401 RADI ATI ON-ONCOLOGY 0.000000 56. 00 05600 RADI OI SOTOPE 0.000000 56. 01 05601 NUCLEAR MEDI CI NE 0.000000 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 60. 00 06000 LABORATORY 0.000000 60.00 64. 00 06400 INTRAVENOUS THERAPY 0.000000 60.00 65. 00 06500 RESPI RATORY THERAPY 0.000000 65.00 66. 00 06600 PHYSI CAL THERAPY 0.000000 66.00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 66.00 68. 00 O6800 SPECH PATHOLOGY 0.000000 68.00 69. 01 06900 ELECTROCARDI OLOGY 0.000000 68.00 69. 01 06901 CARDI AC REHAB 0.000000 69.01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 73. 01 07300 IWPL. DEV. CHARGED TO PATI ENTS 0.000000					
56. 00 05600 RADI OI SOTOPE 0.000000 56. 00 56. 01 05601 NUCLEAR MEDI CI NE 0.000000 56. 01 05900 CARDIA CC CATHETERI ZATI ON 0.000000 59. 00 05900 CARDIA CC CATHETERI ZATI ON 0.000000 60. 00					
56. 01 05601 NUCLEAR MEDICINE 0.000000 59. 00 59. 00 60. 00					
59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 60.00 06000 LABORATORY 0.000000 60.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 64.00 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.01 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.01 0A901 CARDI AC REHAB 0.000000 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 73.01 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.01 74.00 07400 RENAL DI ALYSIS 0.000000 74.00 0017A00 TLIRA SOUND 0.000000 74.00 90.00 91.00 09000 CLI NI C 0.000000 90.00					
60. 00 06000 LABORATORY 0. 000000 64. 00 64. 00 64. 00 10 10 10 10 10 10 10					l
64. 00					
65. 00					
66. 00					
67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 01 06901 CARDI AC REHAB 0.000000 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 0.000000 70. 00					
68. 00		1			ı
69. 00					
69. 01 06901 CARDI AC REHAB 0.000000 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENT 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENT 0.000000 73. 01 74. 00 07301 ULTRA SOUND 0.000000 73. 01 74. 00 07400 RENAL DIALYSIS 0.000000 74. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0.000000 91. 00 91. 00 09100 EMERGENCY 0.000000 92. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 200. 00 Less Observation Beds 200. 00 201. 00 Less Observation Beds		1			
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 07301 ULTRA SOUND 0. 000000 0. 000000 73. 01 07400 RENAL DI ALYSIS 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000					
71. 00		1			ı
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 000000 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 73. 01 07301 ULTRA SOUND 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000					
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 01 07301 ULTRA SOUND 0.000000 74. 00 07400 RENAL DI ALYSIS 0.000000 0.000000 74. 00 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1			
73. 01 07301 ULTRA SOUND 0.000000 74. 00 07400 RENAL DI ALYSI S 0.000000 74. 00 000000 000000 000000 000000 000000					
74. 00 07400 RENAL DI ALYSI S 0.000000 74. 00		1			
OUTPATIENT SERVICE COST CENTERS O0000					l
90. 00 09000 CLINIC 0.000000 91. 00 09100 EMERGENCY 0.000000 91. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 00 Subtotal (see instructions) Less Observation Beds 201. 00		0. 000000			74.00
91.00 09100 EMERGENCY 0.000000 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 200.00 Subtotal (see instructions) Less Observation Beds 201.00					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					
200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					
201.00 Less Observation Beds 201.00		0. 000000			
202.00	1				
	202.00 Iotal (see Instructions)				202.00

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	Provider CCN: 15-0005		Worksheet D	
				From 01/01/2021 To 12/31/2021		narod:
				10 12/31/2021	5/26/2022 12:	
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	4, 252, 251		4, 252, 25			
31.00 INTENSIVE CARE UNIT	595, 996		595, 99			
43. 00 NURSERY	192, 247		192, 24	7 2, 431	79. 08	
44.00 SKILLED NURSING FACILITY	0			0	0.00	
200.00 Total (lines 30 through 199)	5, 040, 494		5, 040, 49	4 26, 963		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
LABORT FUT DOUTLAS OFFICE COOT OFFITEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS		1 100 501				
30. 00 ADULTS & PEDIATRICS	5, 648		1			30.00
31. 00 INTENSIVE CARE UNIT	1, 001	181, 441				31.00
43. 00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
200.00 Total (lines 30 through 199)	6, 649	1, 311, 945	1			200. 00

Health Financial Systems	HENDRI CKS REG	IONAL HEALTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2021	Part II	
				To 12/31/2021	Date/Time Pre	
					5/26/2022 12:	56 pm
		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	2 00	4 00	E 00	

		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)	-		
	col. 26)					
	1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 959, 666	94, 077, 984	0. 020830	6, 252, 376	130, 237	50.00
50. 01 05001 ENDOSCOPY	743, 359	17, 452, 974	0. 042592	571, 268	24, 331	50. 01
51.00 05100 RECOVERY ROOM	1, 285, 657	17, 040, 106	0. 075449	671, 808	50, 687	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	578, 813	18, 833, 482	0. 030733	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	46, 181	24, 236, 949	0. 001905	1, 522, 712	2, 901	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 536, 054	95, 938, 023	0. 016011	4, 676, 020	74, 868	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	459, 404	30, 080, 493	0. 015272	106, 487	1, 626	54.01
56. 00 05600 RADI 0I SOTOPE	0	0	0.000000	0	0	56.00
56. 01 05601 NUCLEAR MEDICINE	31, 565	9, 245, 411	0. 003414	250, 577	855	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	462, 290	36, 740, 184	0. 012583	4, 556, 946	57, 340	59.00
60. 00 06000 LABORATORY	740, 305	97, 922, 869	0. 007560	7, 651, 968	57, 849	60.00
64. 00 06400 I NTRAVENOUS THERAPY	286, 722	25, 729, 623		49, 006	546	64.00
65. 00 06500 RESPIRATORY THERAPY	571, 929	24, 697, 020	0. 023158	3, 980, 991	92, 192	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 020, 147	25, 401, 911	0. 040160	852, 703	34, 245	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	248, 916	3, 248, 754		492, 086	37, 703	67.00
68. 00 06800 SPEECH PATHOLOGY	111, 157	2, 121, 473	0. 052396	205, 127	10, 748	68.00
69. 00 06900 ELECTROCARDI OLOGY	226, 491	24, 247, 322		2, 333, 073	21, 793	69.00
69. 01 06901 CARDI AC REHAB	214, 611	2, 769, 303		5, 008	388	
70. 00 07000 ELECTROENCEPHALOGRAPHY	122, 249	1, 000, 226	0. 122221	103, 415	12, 639	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	72, 692	27, 938, 163	0. 002602	2, 984, 307	7, 765	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	523, 395	123, 035, 827	0. 004254	8, 010, 920	34, 078	73.00
73. 01 07301 ULTRA SOUND	37, 785	12, 880, 687		947, 947	2, 780	73. 01
74. 00 07400 RENAL DI ALYSI S	3, 921	382, 725		172, 802	1, 770	74.00
OUTPATIENT SERVICE COST CENTERS				,	, -	
90. 00 09000 CLI NI C	724, 171	39, 101, 370	0. 018520	310	6	90.00
91. 00 09100 EMERGENCY	1, 595, 581	119, 082, 801		8, 296, 429	111, 164	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	799, 046	5, 141, 891		456, 898	71, 001	
200.00 Total (lines 50 through 199)	14, 402, 107			55, 151, 184	· ·	
			. '			•

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/26/2022 12:	pared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Healt	n Allied Health	All Other	
·	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown	Ŭ	Adjustments		Educati on	
	Adjustments		1		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	0	31.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0		44.00
200.00 Total (lines 30 through 199)	0	Ô		0 0	n	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem	I npati ent	200.00
oost center beserretten	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	Jayo	col. 6)	l og. a bajo	
	instructions)			001. 0)		
	4. 00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	21, 24	4 0.00	5, 648	30.00
31. 00 03100 I NTENSI VE CARE UNI T		0	3, 28			1
43. 00 04300 NURSERY		Ô	2, 43		,	
44.00 04400 SKILLED NURSING FACILITY			1	0.00	Ö	1
200.00 Total (lines 30 through 199)			1			200.00
Cost Center Description	Inpati ent		20, 70	· 5	0,047	200.00
oust defiter bescription	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9, 00					
INPATIENT ROUTINE SERVICE COST CENTERS	7. 00	<u></u>				
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 NTENSI VE CARE UNI T	0					31.00
43. 00 04300 NURSERY	0					43.00
44. 00 04400 SKILLED NURSING FACILITY	0					44.00
	_					
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	HENDRICKS REGION	AL HEALTH	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0005	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2021	Part IV Date/Time Propared:

TIROUGH COSTS				Го 12/31/2021	Date/Time Pre 5/26/2022 12:	
		Title	xVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0	0	50.00
50. 01 05001 ENDOSCOPY	0	0		0	0	50. 01
51.00 05100 RECOVERY ROOM	0	0		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0)	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0	0)	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0)	0	0	56.00
56. 01 05601 NUCLEAR MEDICINE	0	0)	0	0	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	1 0	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
69. 01 06901 CARDI AC REHAB	0	0		0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
73. 01 07301 ULTRA SOUND	0	0		0	0	73. 01
74. 00 07400 RENAL DI ALYSI S	0	0		0	0	74.00
OUTPATIENT SERVICE COST CENTERS	_					
90. 00 09000 CLI NI C	0	0		0	0	90.00
91. 00 09100 EMERGENCY		ا ا		0	414, 739	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1)			0	92.00
200.00 Total (lines 50 through 199)		0		0	414, 739	

Health Financial Systems	HENDRICKS REGION	AL HEALTH	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0005	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/26/2022 12:56 pm

			Т	o 12/31/2021	Date/Time Pre 5/26/2022 12:	
		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	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	1	· · ·		
50. 01 05001 ENDOSCOPY	0	0	C		l	1
51. 00 05100 RECOVERY ROOM	0	0	C	,	l	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C		l	
53. 00 05300 ANESTHESI OLOGY	0	0	C	,		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	95, 938, 023		
54. 01 05401 RADI ATI ON-ONCOLOGY	0	0	C	30, 080, 493		
56. 00 05600 RADI 0I SOTOPE	0	0	C	0	0. 000000	1
56. 01 05601 NUCLEAR MEDICINE	0	0	C	9, 245, 411	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	C	36, 740, 184	l	1
60. 00 06000 LABORATORY	0	0	[C	97, 922, 869	l e	1
64. 00 06400 I NTRAVENOUS THERAPY	0	0	[C	25, 729, 623	l .	
65. 00 06500 RESPI RATORY THERAPY	0	0	[C	24, 697, 020		
66. 00 06600 PHYSI CAL THERAPY	0	0	[C	25, 401, 911	0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	[C	3, 248, 754		
68. 00 06800 SPEECH PATHOLOGY	0	0	[C	2, 121, 473		
69. 00 06900 ELECTROCARDI OLOGY	0	0	[C	24, 247, 322		
69. 01 06901 CARDI AC REHAB	0	0	[C	2, 769, 303		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	[C	1, 000, 226		1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0.000000	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	27, 938, 163	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	123, 035, 827		
73.01 07301 ULTRA SOUND	0	0	C	,,		
74. 00 07400 RENAL DIALYSIS	0	0	C	382, 725	0. 000000	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				
91. 00 09100 EMERGENCY	0	414, 739	414, 739		l	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	C		l	1
200.00 Total (lines 50 through 199)	0	414, 739	414, 739	878, 347, 571		200.00

Health Financial Systems HENDRICKS REGIONAL HEALTH	In Lieu	u of Form CMS-2	552-10
	riod: om 01/01/2021 12/31/2021	Worksheet D Part IV Date/Time Prep 5/26/2022 12:	
Title XVIII	Hospi tal	PPS	
Cost Center Description Outpatient Inpatient Inpatient	Outpati ent	Outpati ent	
Ratio of Cost Program Program	Program	Program	
to Charges Charges Pass-Through	Charges	Pass-Through	

		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	6, 252, 376	C	12, 623, 677	0	50.00
50. 01 05001 ENDOSCOPY	0. 000000	571, 268		3, 402, 286	0	50. 01
51.00 05100 RECOVERY ROOM	0. 000000	671, 808	C	2, 620, 063	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	C	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	1, 522, 712	C	4, 619, 528	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	4, 676, 020	C	16, 516, 902	0	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0. 000000	106, 487	C	9, 167, 246	0	54.01
56. 00 05600 RADI 01 SOTOPE	0. 000000	0	C	0	0	56.00
56. 01 05601 NUCLEAR MEDICINE	0. 000000	250, 577		2, 358, 060		56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	4, 556, 946		6, 088, 197	0	59.00
60. 00 06000 LABORATORY	0. 000000	7, 651, 968	C	5, 456, 486	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	49, 006		6, 636, 451	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	3, 980, 991	C	2, 159, 520	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	852, 703	C	2, 296, 185	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	492, 086	C	44, 052	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	205, 127	C	20, 275	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	2, 333, 073	C	3, 996, 382	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	5, 008	C	998, 069	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	103, 415	C	18, 247	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	C	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	2, 984, 307	C	5, 723, 750	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	8, 010, 920	C	28, 388, 191	0	73.00
73.01 07301 ULTRA SOUND	0. 000000	947, 947	C	2, 182, 849	0	73. 01
74. 00 07400 RENAL DIALYSIS	0. 000000	172, 802	C	4, 226	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	310	C	7, 866, 338	0	90.00
91. 00 09100 EMERGENCY	0. 003483	8, 296, 429	28, 896	14, 630, 529	50, 958	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	456, 898	C	1, 255, 906	0	92.00
200.00 Total (lines 50 through 199)		55, 151, 184	28, 896	139, 073, 415	50, 958	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0005 Worksheet D From 01/01/2021 Part V 12/31/2021 Date/Time Prepared: 5/26/2022 12:56 pm Title XVIII Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To inst.) Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 289739 12, 623, 677 3, 657, 572 50.00 05001 ENDOSCOPY 0 3, 402, 286 721, 652 50.01 0. 212108 0 50.01 51.00 | 05100 | RECOVERY ROOM 0 0. 337002 2,620,063 882, 966 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 331796 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.068469 4, 619, 528 0 0 0 316, 294 53.00 0 2, 633, 950 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.159470 16, 516, 902 54.00 0 54.01 05401 RADI ATI ON-ONCOLOGY 0. 125643 9, 167, 246 1, 151, 800 54.01 56.00 05600 RADI OI SOTOPE 0.000000 0 0 0 0 56.00 0 05601 NUCLEAR MEDICINE 0.090695 2, 358, 060 213, 864 56.01 56.01 05900 CARDIAC CATHETERIZATION 0 429, 991 0.070627 6, 088, 197 59.00 59.00 60.00 06000 LABORATORY 0.149524 5, 456, 486 815, 876 60.00 06400 I NTRAVENOUS THERAPY 0 64.00 0.097622 6, 636, 451 0 0 647, 864 64.00 0 06500 RESPIRATORY THERAPY 2, 159, 520 65 00 0 276270 596, 611 65 00 0 66.00 06600 PHYSI CAL THERAPY 0.493332 2, 296, 185 1, 132, 782 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.345669 44, 052 0 0 15, 227 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 0. 368733 20, 275 7, 476 68.00 0 0 06900 ELECTROCARDI OLOGY 0.098502 3, 996, 382 393, 652 69 00 69 00 69.01 06901 CARDI AC REHAB 0.605396 998, 069 604, 227 69.01 07000 ELECTROENCEPHALOGRAPHY 0.442018 0 70.00 18, 247 8,066 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 0.454131 5, 723, 750 0 2, 599, 332 72 00 72 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0. 301661 28, 388, 191 44, 603 8, 563, 610 73.00 07301 ULTRA SOUND 2, 182, 849 0 158, 182 73.01 73.01 0.072466 0 07400 RENAL DIALYSIS 0 6, 261 74.00 1.481479 4, 226 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 173203 7, 866, 338 0 1, 362, 473 90.00 14, 630, 529 91. 00 09100 EMERGENCY 0.142850 0 ol 2,089,971 91.00 οĺ 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 1.175468 1, 255, 906 1, 476, 277 0 0 200.00 Subtotal (see instructions) 139, 073, 415 44, 603 30, 485, 976 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges

139, 073, 415

0

44, 603

30, 485, 976 202. 00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems		HENDRICKS REGIONA	In Lieu	of Form CMS-2552-10	
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES	S AND VACCINE COST			Worksheet D Part V Date/Time Prepared:

				To 12/31/2021	Date/Time Pro	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	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 OPERATING ROOM	0	0	1			50.00
50. 01 05001 ENDOSCOPY	0	0)			50. 01
51.00 05100 RECOVERY ROOM	0	0)			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)			52.00
53. 00 05300 ANESTHESI OLOGY	0	0)			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)			54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0	0)			54.01
56. 00 05600 RADI 0I SOTOPE	0	0				56.00
56. 01 05601 NUCLEAR MEDICINE	0	0				56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
64.00 06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
69. 01 06901 CARDI AC REHAB	0	0				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0)			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	13, 455	1			73. 00
73. 01 07301 ULTRA SOUND	0					73. 01
74. 00 07400 RENAL DIALYSIS	0	0				74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0		1			90.00
91. 00 09100 EMERGENCY	0	0	1			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1			92.00
200.00 Subtotal (see instructions)	0	13, 455	1			200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	13, 455	1			202.00

Heal th	Financial Systems	HENDRICKS REGIONA	AL HEALTH	In lie	u of Form CMS-2	2552_10
	ATION OF INPATIENT OPERATING COST	TIENDRI ORS REGION	Provi der CCN: 15-0005	Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 12:	pared:
			Title XVIII	Hospi tal	PPS	30 piii
	Cost Center Description				-	
	I				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1. 00	Inpatient days (including private room days	and swing-bed days	s excluding newborn)		21, 244	1.00
2. 00	Inpatient days (including private room days,				21, 244	2.00
3. 00	Private room days (excluding swing-bed and o			rivate room days,	0	3.00
	do not complete this line.					
4. 00	Semi-private room days (excluding swing-bed				17, 252	4. 00
5. 00	Total swing-bed SNF type inpatient days (inc	cluding private ro	om days) through Decemb	er 31 of the cost	0	5. 00
/ 00	reporting period			21 -6 -1	0	/ 00
6. 00	Total swing-bed SNF type inpatient days (increporting period (if calendar year, enter 0		om days) arter becember	31 Of the Cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (incl		m days) through Decembe	r 31 of the cost	0	7.00
7.00	reporting period	daring private roof	" days) thi dagit becombe	1 01 01 110 0031	O	7.00
8. 00	Total swing-bed NF type inpatient days (incl	uding private room	m days) after December	31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0	on this line)				
9.00	Total inpatient days including private room	days applicable to	o the Program (excludin	g swing-bed and	5, 648	9. 00
40.00	newborn days) (see instructions)					40.00
10. 00	Swing-bed SNF type inpatient days applicable	e to title XVIII or	nly (including private	room days)	0	10.00
11. 00	through December 31 of the cost reporting po Swing-bed SNF type inpatient days applicable	eriod (see instruc	ulv (including privato	room days) after	0	11.00
11.00	December 31 of the cost reporting period (if	f calendar vear le	nter 0 on this line)	days) arter	U	11.00
12. 00						
	through December 31 of the cost reporting period					
13.00	Swing-bed NF type inpatient days applicable				0	13.00
	after December 31 of the cost reporting peri				_	
14.00	Medically necessary private room days applic	cable to the Progra	am (excluding swing-bed	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)				0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT				0	10.00
17. 00	Medicare rate for swing-bed SNF services app	olicable to service	es through December 31	of the cost	0.00	17. 00
	reporting period		3			
18.00	Medicare rate for swing-bed SNF services app	olicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period					
19. 00	Medicaid rate for swing-bed NF services appl	icable to services	s through December 31 o	f the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services appl	icable to service	after December 21 of	the cost	0. 00	20.00
20.00	reporting period	reable to service.	s arter becember 51 or	the cost	0.00	20.00
21. 00	Total general inpatient routine service cost	t (see instructions	5)		32, 164, 699	21.00
22.00	Swing-bed cost applicable to SNF type service	ces through Decembe	er 31 of the cost repor	ting period (line	0	22. 00
	5 x line 17)					
23. 00] 3	ces after December	31 of the cost reporti	ng period (line 6	0	23. 00
24.00	x line 18)	+b	- 21 -6 +6+		0	24.00
24. 00	Swing-bed cost applicable to NF type service 7×1 ine 19)	es through becember	31 of the cost report	ing period (iine	0	24. 00
25. 00						
00	x line 20)			5 , (· ·	25. 00
26.00						
27. 00	General inpatient routine service cost net o	of swing-bed cost	(line 21 minus line 26)		32, 164, 699	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			, ,		
28. 00	General inpatient routine service charges (d and observation bed c	narges)	0	28.00
29.00	Private room charges (excluding swing-bed ch				0	29. 00 30. 00
30. 00 31. 00	Semi-private room charges (excluding swing-b General inpatient routine service cost/charc		: line 28)		0. 000000	31.00
555	1	y G O (11110 Z/			5. 555566	

3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4 00	do not complete this line.	47.050	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	17, 252 0	4. 00 5. 00
5.00	reporting period	٥	3.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	-	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	F (40	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	5, 648	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
	through December 31 of the cost reporting period (see instructions)	Ĭ	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period		12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
	Total nursery days (title V or XIX only)	ő	15. 00
	Nursery days (title V or XIX only)	o	
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing had NE carvices applicable to carvices through December 21 of the cost	0.00	10.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	32, 164, 699	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	. 0	22.00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
21.00	7 x line 19)	ĭ	21.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	32, 164, 699	27.00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Private room charges (excluding swing-bed charges)	0	29. 00
	Semi -pri vate room charges (excluding swing-bed charges)	ő	
	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	32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)		35.00
	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	32, 164, 699	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 514. 06	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	8, 551, 411	39. 00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	8, 551, 411	41. 00

Heal th	Financial Systems HENDRICKS REGIONAL HEALTH In Li	eu of Form CMS-2	2552-10
	FATION OF INPATIENT OPERATING COST Provider CCN: 15-0005 Period:	Worksheet D-1	
	From 01/01/202 To 12/31/202		pared:
	Title XVIII Hospital	5/26/2022 12: PPS	56 pm
	Cost Center Description Total Total Average Per Program Days	-	
	Inpatient Inpatient Diem (col. 1	(col. 3 x	
	Cost Days ÷ col . 2) 1.00 2.00 3.00 4.00	col . 4) 5.00	
42.00			42.00
	Intensive Care Type Inpatient Hospital Units		
43. 00 44. 00	INTENSIVE CARE UNIT	2, 202, 020	43. 00 44. 00
	BURN INTENSIVE CARE UNIT		44. 00 45. 00
46. 00			46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)		47. 00
	Cost Center Description	1.00	
48. 00		12, 379, 556	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	23, 132, 987	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I ar	d 1, 311, 945	50. 00
30.00		1,311,743	30.00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	868, 408	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)	2, 180, 353	52. 00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	20, 952, 634	
	medical education costs (line 49 minus line 52)		
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program di scharges	T 0	54.00
55. 00		0.00	
56. 00		0	56.00
57. 00		0	57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00	58. 00 59. 00
37.00	market basket	0.00	37.00
60.00		0.00	
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target	0	61. 00
	amount (line 56), otherwise enter zero (see instructions)		
62.00		0	62.00
63. 00		0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	. 0	64. 00
	instructions)(title XVIII only)		
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65. 00
66.00		0	66. 00
	CAH (see instructions)		
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
	(line 13 x line 20)		
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	69. 00
70. 00			70. 00
71. 00			71.00
72. 00 73. 00	Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35)		72. 00 73. 00
74. 00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column	ı	75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77.00	, ,		77.00
78. 00	Inpatient routine service cost (line 74 minus line 77)		78. 00
79. 00			79.00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation		80. 00 81. 00
82. 00	Inpatient routine service cost per dreim train (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84. 00 85. 00	Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)		84. 00 85. 00
	Total Program inpatient operating costs (sum of lines 83 through 85)		85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	j , , , , , , , , , , , , , , , , , , ,	3, 992	87.00
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	1, 514. 06 6, 044, 128	
200	1	1 2,011,120	

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 12:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	4, 252, 251	32, 164, 699	0. 13220	2 6, 044, 128	799, 046	90.00
91.00 Nursing Program cost	0	32, 164, 699	0.00000	0 6, 044, 128	ol	91.00
92.00 Allied health cost	0	32, 164, 699	0.00000	0 6, 044, 128	0	92.00
93.00 All other Medical Education	0	32, 164, 699	0.00000	0 6, 044, 128	0	93.00

	Financial Systems HENDRICKS REGIONATION OF INPATIENT OPERATING COST	NAL HEALTH Provider CCN: 15-0005	In Lie	u of Form CMS-2 Worksheet D-1	
		1. 3.7 45. 33 10 3333	From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
		Title XIX	Hospi tal	5/26/2022 12: Cost	oo piii
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				1
1. 00	Inpatient days (including private room days and swing-bed days	avs excluding newborn)		21, 244	1.00
2. 00	Inpatient days (including private room days, excluding swind			21, 244	2.00
3. 00	Private room days (excluding swing-bed and observation bed of		rivate room days	21, 244	3.00
3.00	do not complete this line.	days). If you have only p	irvate room days,	U	3.00
4. 00	Semi-private room days (excluding swing-bed and observation	hed days)		17, 252	4.00
5. 00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	0	5.00
0.00	reporting period	com dayo, tim odgi. become	0. 0. 0	Ü	0.00
6. 00	Total swing-bed SNF type inpatient days (including private r	room days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)	3 ,			
7.00	Total swing-bed NF type inpatient days (including private ro	oom days) through Decembe	r 31 of the cost	0	7.00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private ro	oom days) after December	31 of the cost	0	8.0
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	671	9.00
10 00	newborn days) (see instructions)			0	10.0
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year,		100111 days) arter	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or λ		te room days)	0	12.00
12.00	through December 31 of the cost reporting period	trix only (thereating priva	to room days)	O	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or >	(IX only (includina priva	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendar				
14. 00	Medically necessary private room days applicable to the Prog			0	14.00
15. 00	Total nursery days (title V or XIX only)			2, 431	15.00
16. 00	Nursery days (title V or XIX only)			0	16.0
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0. 00	17.0
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18. 0
10 00	reporting period	thusb Daramban 21 -	6 111	0.00	10.0
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	ces through becember 31 o	Tine cost	0.00	19.0
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	cos after December 21 of	the cost	0. 00	20.0
20.00	reporting period	ces arter becember 31 or	the cost	0.00	20.0
21. 00	Total general inpatient routine service cost (see instruction	ons)		32, 164, 699	21.0
22. 00	Swing-bed cost applicable to SNF type services through Decem		ting period (line		ı
	5 x line 17)		ting pointed (init	· ·	==: 0
23. 00	Swing-bed cost applicable to SNF type services after December	er 31 of the cost reporti	na period (line d	0	23.0
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost report	ing period (line	0	24.0
	7 x line 19)	•	• •		
25. 00	Swing-bed cost applicable to NF type services after December	⁻ 31 of the cost reportin	g period (line 8	0	25.0
	x line 20)				
26. 00	Total swing-bed cost (see instructions)			0	26.0

	PART I - ALL PROVIDER COMPONENTS INDATIENT DAYS		
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn)	21, 244	1.0
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21, 244	2.0
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.0
4 00	do not complete this line.	17 050	4.0
4.00	Semi-private room days (excluding swing-bed and observation bed days)	17, 252	4.0
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.0
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.0
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.0
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.0
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	671	9.0
	newborn days) (see instructions)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.0
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. (
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. (
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. (
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	Ü	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. (
15. 00	Total nursery days (title V or XIX only)	2, 431	
16. 00		2, 431	16. (
16.00	Nursery days (title V or XIX only)	0	16.0
47.00	SWING BED ADJUSTMENT	0.00	47.
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. (
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. (
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. (
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.0
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	32, 164, 699	21. 0
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.0
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.0
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.0
	7 x li ne 19)	-	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. (
20.00	x line 20)	Ü	
26. 00	Total swing-bed cost (see instructions)	0	26.0
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	32, 164, 699	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	32, 104, 077	27.0
20.00		0	20 6
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.0
29. 00	Private room charges (excluding swing-bed charges)	0	29. (
30.00	Semi - pri vate room charges (excluding swing-bed charges)	0	30.0
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34. (
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. (
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36. (
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	32, 164, 699	37.0
	27 minus Line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 514. 06	38.0
39.00	Program general inpatient routine service cost (line 9 x line 38)	1, 015, 934	39.0
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	1 015 024	40.
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 015, 934	41.(

	Financial Systems	HENDRI CKS REGI		ON. 15 0005 5		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	F	eriod: rom 01/01/2021	Worksheet D-1	
					o 12/31/2021	Date/Time Pre 5/26/2022 12:	
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	cost center bescription	I npati ent	I npati ent	Diem (col. 1	11 ogram bays	(col. 3 x	
		1.00	2. 00	÷ col. 2) 3.00	4.00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only)	3, 239, 516	2, 431				42.00
40.00	Intensive Care Type Inpatient Hospital Units		2 200	0 400 00			40.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	7, 233, 004	3, 288	2, 199. 82	0	0	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00 47. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
40.00	December 1 and 1 a	-+ D 21 3	11: 200)			1.00	40.00
	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		896, 777 1, 912, 711	
	PASS THROUGH COST ADJUSTMENTS	,		,			
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (fi	rom Wkst. D, s	um of Parts II	О	51.00
F0 00	and IV)	E0 L E4)					F0 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated non-ph	vsician anesth	etist and	0	
	medical education costs (line 49 minus line						
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)				50)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (line 56 minus	line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, i	updated and co	mpounded by the	· ·	
40.00	market basket	cost roport ur	adatad by the	markat backat		0.00	60.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	1
	which operating costs (line 53) are less tha	n expected cost					
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	Instructions)				0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	na period (See	0	64.00
	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the o	cost reporting	period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [ecember 31 of	the cost reno	rting period	0	68.00
	(line 13 x line 20)			·	rting period		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	utine service (cost (line 37)			70. 00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic	,	n (line 14 x li	ine 35)			73.00
74.00	Total Program general inpatient routine serv	•					74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from)	Worksheet B, P	art II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	,					77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	,	provi der recor	ds)			79.00
80.00	Total Program routine service costs for comp		cost limitation	n (line 78 min	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see instruction	* .				83.00
84.00	Program inpatient ancillary services (see in		one)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	J /				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	: line 2)			3, 992 1, 514. 06	
	Observation bed cost (line 87 x line 88) (se	•	•			6, 044, 128	
	, ,						

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 12:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	4, 252, 251	32, 164, 699	0. 13220	2 6, 044, 128	799, 046	90.00
91.00 Nursing Program cost	0	32, 164, 699	0.00000	0 6, 044, 128	ol	91.00
92.00 Allied health cost	0	32, 164, 699	0.00000	0 6, 044, 128	0	92.00
93.00 All other Medical Education	0	32, 164, 699	0.00000	0 6, 044, 128	0	93.00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0005	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Pre	
		—			5/26/2022 12:	
		litle	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
0.00	03000 ADULTS & PEDI ATRI CS			11, 446, 271		30.0
1. 00	03100 INTENSIVE CARE UNIT			4, 229, 198		31.0
3.00	04300 NURSERY					43.
0 00	ANCILLARY SERVICE COST CENTERS		0.0007		4 044 557	
0.00	O5000 OPERATI NG ROOM O5001 ENDOSCOPY		0. 28973			
1. 00	05100 RECOVERY ROOM		0. 21210 0. 33700			
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 3370		226, 401 0	
3.00	05300 ANESTHESI OLOGY		0. 06846			
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1594			1
4. 01	05401 RADI ATI ON-ONCOLOGY		0. 12564		13, 379	
6. 00	05600 RADI OI SOTOPE		0.00000		0	1
6. 01	05601 NUCLEAR MEDICINE		0. 09069		22, 726	
9. 00	05900 CARDI AC CATHETERI ZATI ON		0. 07062	27 4, 556, 946	321, 843	59.
00 .0	06000 LABORATORY		0. 14952	24 7, 651, 968	1, 144, 153	60.
4. 00	06400 I NTRAVENOUS THERAPY		0. 09762	22 49, 006	4, 784	64.
5. 00	06500 RESPI RATORY THERAPY		0. 2762		1, 099, 828	
5. 00	06600 PHYSI CAL THERAPY		0. 49333			
7. 00	06700 OCCUPATI ONAL THERAPY		0. 34566			
3. 00	06800 SPEECH PATHOLOGY		0. 36873			
9.00	06900 ELECTROCARDI OLOGY		0. 09850			
9. 01	06901 CARDI AC REHAB		0. 60539	·		
0. 00 1. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4420		45, 711 0	
2. 00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 00000		1, 355, 266	
3.00	07300 DRUGS CHARGED TO PATIENTS		0. 3016			1
3. 01	07301 ULTRA SOUND		0. 07246		68, 694	1
	07400 RENAL DI ALYSI S		1. 4814			
00	OUTPATIENT SERVICE COST CENTERS		1. 1011	172,002	200,000	1 ′ ′′
0. 00	09000 CLI NI C		0. 17320	03 310	54	90.
1. 00	09100 EMERGENCY		0. 1428			
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 17546			
00.00				55, 151, 184	12, 379, 556	200.
01.00		es (line 61)		0		201.
02.00				55, 151, 184		202.

	Financial Systems HENDRICKS REGIO	Provi der C	CN: 15-0005	Peri od:	u of Form CMS-2 Worksheet D-3	
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/26/2022 12:	:pared: 56 pm
		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	
			1.00	2.00	col . 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS			2, 336, 522		30.00
31. 00	03100 INTENSIVE CARE UNIT			272, 877		31.00
43.00	04300 NURSERY			390, 391		43.00
	ANCILLARY SERVICE COST CENTERS					4
50. 00	05000 OPERATING ROOM		0. 2897			
50. 01	05001 ENDOSCOPY		0. 21210			
51.00	05100 RECOVERY ROOM		0. 3370		15, 100	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY		0. 33179 0. 06849		0 8, 026	1
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 06840			•
54. 00	05400 RADI OLOGI - DI AGNOSTI C		0. 1256		0 30, 103	
56. 00	05600 RADI OI SOTOPE		0. 00000		Ö	
56. 01	05601 NUCLEAR MEDICINE		0. 09069			
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 0706			
60.00	06000 LABORATORY		0. 1495	24 760, 217		1
64. 00	06400 I NTRAVENOUS THERAPY		0. 09762	22 2, 515	246	64.00
65.00	06500 RESPI RATORY THERAPY		0. 2762			
66. 00	06600 PHYSI CAL THERAPY		0. 4933			
67.00	06700 OCCUPATI ONAL THERAPY		0. 3456			
68.00	O6800 SPEECH PATHOLOGY O6900 ELECTROCARDI OLOGY		0. 36873 0. 09850			
69. 00 69. 01	06901 CARDI AC REHAB		0. 09850		13, 923 619	
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 4420		3, 100	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000			1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 4541		127, 269	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 3016	·		
73. 01	07301 ULTRA SOUND		0. 0724	·		
74. 00	07400 RENAL DIALYSIS		1. 4814	79 8, 906	13, 194	74.00
	OUTPATIENT SERVICE COST CENTERS					4
90. 00	09000 CLI NI C		0. 17320			
91.00	09100 EMERGENCY		0. 1428!	·		•
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 1754			
200.00		oo (line (1)		4, 119, 865	896, 777	
201.00	Less PBP Clinic Laboratory Services-Program only charg	es (iine 61)	1	1 0	I	201.00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 12:56 pm

PARE A IMPAILEM! HSSPITAL SERVICES UNDER LIPSS 1.00				10 12/31/2021	5/26/2022 12:	
No. DRAFT A IMPATIBIT MOSPITAL SERVICES WIRER IPPS DRAFT A IMPATIBIT MOSPITAL SERVICES WIRER IPPS DRAFT A IMPATIBIT MOSPITAL SERVICES WIRER IPPS DRAFT A IMPATIBIT MOST A IMPATIBIT M			Title XVIII	Hospi tal		
No. DRAFT A IMPATIBIT MOSPITAL SERVICES WIRER IPPS DRAFT A IMPATIBIT MOSPITAL SERVICES WIRER IPPS DRAFT A IMPATIBIT MOSPITAL SERVICES WIRER IPPS DRAFT A IMPATIBIT MOST A IMPATIBIT M					1.00	
1.00 BisS Amounts other than duftiler Payments for discharges occurring prior to October 1 (see 1.0.31,760 1.0.01 1.0.0		DART A _ INDATIENT HOSPITAL SERVICES LINDER LDRS			1.00	
1.00 BGC amounts other than outlier payments for discharges occurring prior to October 1 (see 12,631,760 1.01	1 00				0	1 00
DRC amounts other than outlier payments for discharges occurring on or after October 1 (see 4,312,788 1.02 DRC for frestructions DRC for frestructions DRC for frestructions 0 1.03 DRC for frestructions DRC for frestructions 0 1.03 DRC for frestructions 0 1.04 Cottober 1 (see Instructions) 0 1.04 Cottober 1 (see Instructions) 0 1.04 Cottober 1 (see Instructions) 0 0.01 Outlier payments for discharges (see Instructions) 0 2.00 Outlier payments for discharges (see Instructions) 70 0 2.00 Outlier payments for discharges cocurring prior to October 1 (see Instructions) 70 0 2.00 Outlier payments for discharges cocurring prior to October 1 (see Instructions) 220, 321 Outlier payments for discharges cocurring on or after October 1 (see Instructions) 200, 300 Outlier payments for discharges cocurring on or after October 1 (see Instructions) 200, 300 Outlier payments for discharges cocurring on or after October 1 (see Instructions) 200, 300 Outlier payments for discharges cocurring on or after October 1 (see Instructions) 200, 300 Outlier payments for discharges cocurring on or after October 1 (see Instructions) 200, 300 Outlier payments for discharges cocurring on or after October 1 (see Instructions) 200, 300 Outlier payments for discharges cocurring on or after October 1 (see Instructions) 300 Outlier payments for discharges cocurring on or after October 1 (see Instructions) 300 Outlier payments for discharges cocurring on or after October 1 (see Instructions) 300 Outlier payments for discharges (see Instructions) 300 Outlier the outlier of the Outlier of See Instructions 300 Outlier the Outlier of See Instructions 300 Outlier the Outlier of See Instructions 300 Out		DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 ((see		
Instructions	1 02		ing on or often October	1 (500	1 212 702	1 02
1.00 DRC for Foderal specific operating payment for Woole 1 8PCI for discharges occurring prior to October 1 (1.04 1.04 1.05	1. 02		ing on or after october	i (See	4, 312, 783	1.02
1.04 October 1 (see instructions) 2.00 Outlier payments for discharges (see instructions) 2.00 Outlier payments for discharges (see instructions) 2.00 Outlier payments for discharges (see instructions) 798.688 2.03 2.03 Outlier payments for discharges (see instructions) 798.688 2.03 2.04 Outlier payments for discharges occurring prior to October 1 (see instructions) 798.688 2.03 2.04 Outlier payments for discharges occurring prior to October 1 (see instructions) 798.688 2.03 2.04 Outlier payments for discharges occurring prior to October 1 (see instructions) 229, 373 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 118.84 4.04 0.05 0.0	1. 03	DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	prior to October	. 0	1. 03
2.00 Outlier payments for discharges (see Instructions) 0.20 Outlier payment for discharges for Model 4 BPCI (see Instructions) 798,688 2.03 Outlier payments for discharges occurring prior to October 1 (see Instructions) 798,688 2.03 Outlier payments for discharges occurring prior to October 1 (see Instructions) 798,689 2.03 Outlier payments for discharges occurring prior to October 1 (see Instructions) 729,373 2.04 4.00 Outlier payments for discharges occurring on or after October 1 (see Instructions) 729,373 2.04 4.00 Outlier payments for discharges occurring on or after October 1 (see Instructions) 729,373 2.04 4.00 Outlier payments for discharges occurring period (see instructions) 729,373 2.04 720,373 72	1. 04	DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	on or after	0	1.04
2.01 Outlier resonatiation amount 0 2.01	2. 00				 -	2.00
Outlier payments for discharges occurring or to october 1 (see instructions) 778, 688 2.04	2.01	Outlier reconciliation amount			0	2. 01
2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 229, 373 2.04	2.02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2. 02
Managed Car's Simulated Payments 0 3.00	2.03	Outlier payments for discharges occurring prior to October 1	(see instructions)		798, 658	2. 03
Bed days available divided by number of days in the cost reporting period (see instructions) 18.84 4.00			1 (see instructions)		229, 373	
Indirect Medical Education Adjustment Count for all lopathic and ostepathic programs for the most recent cost reporting period ending of or before 12/31/1996, (see Instructions) 6.00 FIEC count for all lopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR \$413.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the cook report straddled so July 1, 2011 then see instructions 8.00 Adjustment (increase or decrease) to the FIE count for all opathic and osteopathic programs for application of increase or decrease) to the FIE count for all opathic and osteopathic programs for application of increase if the hospital was awarded FIE cap slots under \$500 of ACA. If the cost report straddled suly 1, 2011 see instructions. 8.02 The amount of increase if the hospital was awarded FIE cap slots under \$500 of ACA. (see Instructions) 8.03 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 9.00 instructions) 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 9.00 instructions) 9.01 FIE count for all opathic and osteopathic programs in the current year from your records 0.00 11.00 FIE count for all opathic and osteopathic programs in the current year from your records 0.00 11.00 FIE count for the penul tinate programs in the current year from your records 0.00 11.00 FIE count for the penul tinate year if that year ended on or after September 30, 1997, 0.00 11.00 FIE count for the penul tinate year if that year ended on or after September 30, 1997, 0.00 11.00 FIE count for the penul tinate year if that year ended on or after September 30, 1997, 0.00 11.00 FIE count for the penul tinate year if that year ended on or after September 30, 1997, 0.00 11.00 FIE count for the penul tinate year if that year ended on or after September 30, 1997, 0.00 11.00 FIE count for the penul tinate year if that year ended o		, ,				1
FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending of or before 12/31/19/96, (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 8.00 Adjustment (increase or decrease) to the FTE count for all lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50090 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddle slubse if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5500 of ACA. (see instructions) 8.02 9.03 9.04 9.05 9.05 9.05 9.06 9.06 9.07 9.07 9.07 9.08 9.09 9.09 9.09 9.09 9.09 9.09 9.09	4. 00		orting period (see instru	uctions)	118. 84	4.00
or before 12/31/1996, (see instructions) 7.00 Fore count for all lopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 7.01 ACA \$5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost cost report straddles July 1, 2011 then see instructions. 8.00 Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under \$5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$5506 of ACA. (see instructions) 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 linstructions) 10.00 FTE count for residents in dental and pod atric programs. 10.01 FTE count for residents in dental and pod atric programs. 10.02 FTE count for residents in the ponult imate year if that year ended on or after September 30, 1997, 11.00 local allowable FTE count for the prior year. 10.00 Sum of lines 12 through 14 divided by 3. 10.00 Sum of lines 12 through 14 divided by 3. 10.00 Current year all owable FTE count 10.00 Current year residents in initial years of the program 10.00 Current year resident to bed ratio (see instructions) 10.00 Current year resident to bed ratio (see instructions) 10.00 Current year resident to bed ratio (see instructions) 10.00 Current year resident to bed ratio (see instructions) 10.00 Current year resident to bed ratio (see instructions) 10.00 Current year resident to bed ratio (see instructions) 10.00 Current year resident to bed ratio (see instructions) 10	г оо				0.00	F 00
FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(i)(B)(1) 0.00 7.00 7.01 AcA \$5.503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(i)(B)(2) If the cost report straddies July 1, 2011 then see instructions. 0.00 7.00	5.00		st recent cost reporting	period ending on	0.00	5.00
7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 0.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 8.00	6. 00	FTE count for allopathic and osteopathic programs that meet t	he criteria for an add-d	on to the cap for	0.00	6. 00
ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(1)(8)(2) If the cost report strandide sully 1, 2011 then see instructions.	7 00	1 9	under 42 CED 8412 105(f)	(1) (i) (P) (1)	0.00	7 00
cost report straddles July 1, 2011 then see instructions. 8.00 All ustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affil i ated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv). 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5500 of ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions). 8.02 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 9.00 instructions). 8.03 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 11.00 Current year allowable FTE (see instructions). 8.04 Current year allowable FTE (see instructions). 8.05 Sum of lines 12 through 14 divided by 3. 8.06 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 8.00 All ustment for residents in initial years of the program 0.00 17.00 All ustment for residents in initial years of the program 0.00 17.00 All ustment for residents in initial years of the program 0.00 17.00 All ustment for residents in initial years of the program 0.00 17.00 All ustment for residents in initial years of the program 0.00 17.00 Current year resident to bed ratio (see instructions) 0.00 Current year resident to bed ratio (see instructions) 0.000000 2.00 Direct West or year resident to bed ratio (see instructions) 0.000000 2.00 Direct West or year resident to bed ratio (see instructions) 0.000000 2.00 Direct West or year resident to bed ratio (see instructions) 0.000000 2.00 Direct West or year resident to bed ratio (see instructions) 0.000000 2.00 Direct West or year resident to bed ratio (see instructions) 0.000000 2.00 Direct West or year resident to bed ratio (see instructions) 0.000000 2.00 Direct West or year resid						1
Aglustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CER 413.75(b). 413.79(c)(2)(iv). 678 26340 (May 12. 1998), and 67 FR 50069 (August 1, 2002). B. 01	7.01		42 CIR 3412: 103(1)(1)(1	V) (B) (2) 11 the	0.00	7.01
1998, and 67 FR 50009 (August 1, 2002).	8.00		thic and osteopathic pro	ograms for	0.00	8.00
8.01 The amount of Increase If the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions. 8.01		affiliated programs in accordance with 42 CFR 413.75(b), 413.	79(c)(2)(iv), 64 FR 2634	10 (May 12,	 -	
report straddles July 1, 2011, see instructions.		1998), and 67 FR 50069 (August 1, 2002).			 -	
8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	8. 01		ots under § 5503 of the	ACA. If the cost	0.00	8. 01
under \$ 5506 of ACA. (see instructions)	0.00	, ,	-+- £ + -		0.00	0.00
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 9.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 10.00 FTE count for residents in dental and podiatric programs. 0.00 12.00 10.00 1	8. 02		ots from a closed teachi	ng nospitai	0.00	8.02
Instructions	9. 00		nes (8, 8,01 and 8,02)	(see	0.00	9.00
11.00 TEE count for residents in dental and podiatric programs. 0.00 11.00 12.00 13.00 10.00 13.00 10.00 13.00 10.01 10.00 1					1	
12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 10.00	10.00	FTE count for allopathic and osteopathic programs in the curr	ent year from your recor	rds	0.00	10.00
13.00 Total allowable FTE count for the prior year. 0.00 13.00 14.00 14.00 14.00 14.00 15.00	11.00	FTE count for residents in dental and podiatric programs.				
14.00	12.00	Current year allowable FTE (see instructions)			0. 00	12.00
Otherwise enter zero. Sum of lines 12 through 14 divided by 3. 0.00 15.00 16		·				
15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 17.00 18.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 17.00 18.00 0.00 18.00 0.00 18.00 0.00 0.00 18.00 0.00 0.00 19.00 0.00	14. 00		ear ended on or after Sep	otember 30, 1997,	0. 00	14.00
16. 00 Adj ustment for residents in initial years of the program 0.00 16. 00 17. 00 Adj ustment for residents displaced by program or hospital closure 0.00 17. 00 18. 00 Adj usted rolling average FTE count 0.00 18. 00 19. 00 Current year resident to bed ratio (see instructions) 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 00 IME payment adj ustment (see instructions) 0.000000 21. 00 22. 01 IME payment adj ustment - Managed Care (see instructions) 0.000000 22. 01 1 Indirect Medical Education Adj ustment for the Add-on for § 422 of the MMA 0.000000 23. 00 23. 00 (f)(1)(iv)(C). 0.000000 24. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 25. 00 26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 28. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00	45.00				0.00	45.00
17. 00						1
18.00 Adjusted rolling average FTE count 0.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.01 IME payment adjustment (see instructions) 0.22.00 1 IME payment adjustment - Managed Care (see instructions) 0.00 22.01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23.00 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(c). 0.1 1ME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 26.00 1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 27.00 1ME payments adjustment factor. (see instructions) 0.000000 27.00 28.01 1ME add-on adjustment amount (see instructions) 0.28.01		, ,	ouro.			
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0.22.00 1 IME payment adjustment - Managed Care (see instructions) 0.22.01 1 IME payment adjustment - Managed Care (see instructions) 0.00 23.00 (f)(1)(iv)(C) 0.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.000000 27.00 28.01 IME payment (sum of lines 22 and 28) 0.28.00 29.01 Total IME payment (sum of lines 22 and 28) 0.29.00 10 Disproportionate Share Adjustment 30.00 Percentage of SSI reci			isui e			
20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 22.00 0.000000 22.00 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		, ,	1			
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0 22.00 1ME payment adjustment - Managed Care (see instructions) 0 22.01 1 Imig payment adjustment - Managed Care (see instructions) 0 22.01 1 Imig payment adjustment for the Add-on for § 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 25.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 1 IME payments adjustment amount (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.28.01 29.01 Total IME payment (sum of lines 22 and 28) 0.00000 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.000000 29.01 Disproportionate Share Adjustment 30.00 Sum of lines 30 and 31 20.52 32.00 31.00 Sum of lines 30 and 31 20.53 32.00 32.00 Allowable disproportionate share percentage (see instructions) 6.14 33.00 33.00 Allowable disproportionate share percentage (see instructions) 6.14 33.00			·).			
22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 IME payments adjustment factor. (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount - Managed Care (see instructions) 10.02 28.00 IO Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days (see instructions) 10.00 Sum of lines 30 and 31 20.052 32.00 Allowable disproportionate share percentage (see instructions) 6.14 33.00		· · · · · · · · · · · · · · · · · · ·				
22. 01 IME payment adjustment - Managed Care (see instructions) 0 1 1 1 1 1 1 1 1 1		· · · · · · · · · · · · · · · · · · ·				
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00					_	1
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 25.00 Resident to bed ratio (divide line 25 by line 4) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 6.14 33.00	22.0.		2 of the MMA		Ü	
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 32.00 IME add-on adjustment amount - Managed Care (see instructions) 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions)	23. 00			CFR 412. 105	0.00	23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 1ME add-on adjustment amount (see instructions) 1ME add-on adjustment amount - Managed Care (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 10 28.01 Total IME payment (sum of lines 22 and 28) 10 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 10 isproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 6.14 33.00						
instructions						1
26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0 28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0 28.01 29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment 0 29.01 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1.46 30.00 31.00 Sum of lines 30 and 31 20.52 32.00 33.00 Allowable disproportionate share percentage (see instructions) 6.14 33.00	25. 00		lower of line 23 or line	e 24 (see	0. 00	25. 00
27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 30.00 Allowable disproportionate share percentage (see instructions) 30.00 IME payment (sum of lines (see instructions) 30.00 Co.000000 27.00 30.00 28.01 30.00 29.00 30.00 29.00 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 30.00 Co.000000 27.00 30.00 28.01 30.00 29.00 30.00 29.0	24 00	,			0.000000	24 00
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Percentage of Medicaid patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions)		, , , , , , , , , , , , , , , , , , ,				1
28.01 IME add-on adjustment amount - Managed Care (see instructions) 7		, , , , , , , , , , , , , , , , , , , ,				1
29.00 Total IME payment (sum of lines 22 and 28) 0 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1.46 30.00 Percentage of Medicaid patient days (see instructions) 19.06 31.00 Sum of lines 30 and 31 20.52 32.00 Allowable disproportionate share percentage (see instructions) 6.14 33.00		, , , , , , , , , , , , , , , , , , , ,	.)			1
29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.01 29.01 30.02 31.00 31.00 29.01 32.00 31.00 32.00 31.00 31.00 33.00 Allowable disproportionate share percentage (see instructions) 32.01 33.00		,	5)			
Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions)			11)			1
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1. 46 30.00 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 1. 46 30.00 20.52 32.00 31.00 6.14 33.00	27.01				0	1 27.01
31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 19.06 31.00 20.52 32.00 33.00 Allowable disproportionate share percentage (see instructions) 6.14 33.00	30.00		patient days (see instruc	ctions)	1. 46	30.00
32.00 Sum of Lines 30 and 31 20.52 32.00 33.00 Allowable disproportionate share percentage (see instructions) 6.14 33.00			(333311 40			1
33.00 Allowable disproportionate share percentage (see instructions) 6.14 33.00		, , , , , , , , , , , , , , , , , , , ,				1
			5)			
	34.00	Disproportionate share adjustment (see instructions)			260, 099	34.00

	Financial Systems HENDRICKS REGIL LATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	Peri od:	u of Form CMS-2 Worksheet E	2552
ALCUI	ATTON OF REIMBURSEMENT SETTLEMENT	Provider CCN. 15-0005	From 01/01/2021 To 12/31/2021	Part A	nare
			10 12/31/2021	5/26/2022 12:	56 p
		Title XVIII	Hospi tal	PPS	
			Pri or to 10/1		
	Uncompensated Care Adjustment		1. 00	2. 00	
5. 00			0	0	35.
5. 01	Factor 3 (see instructions)		0. 000000000		
5. 02	,	nter zero on this line) (s		2, 258, 328	
	Pro rata share of the hospital uncompensated care payment a Total uncompensated care (sum of columns 1 and 2 on line 35		1, 787, 176 2, 356, 399	569, 223	35. 36.
). 00	Additional payment for high percentage of ESRD beneficiary				30.
0.00	Total Medicare discharges (see instructions)	discharges (Tries to this	0		40.
1. 00	Total ESRD Medicare discharges (see instructions)		0	•	41.
1. 01	Total ESRD Medicare covered and paid discharges (see instru	ıcti ons)	0		41.
2. 00	Divide line 41 by line 40 (if less than 10%, you do not qua	alify for adjustment)	0.00		42
3. 00	Total Medicare ESRD inpatient days (see instructions)	,	0		43
. 00	Ratio of average length of stay to one week (line 43 divide days)	ed by line 41 divided by 7	0. 000000		44
. 00	Average weekly cost for dialysis treatments (see instruction	ons)	0. 00		45
. 00	Total additional payment (line 45 times line 44 times line	41. 01)	0		46
. 00	,		20, 589, 072		47
. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48
	only. (see instructions)			Amount	
				1. 00	
. 00	Total payment for inpatient operating costs (see instruction	ons)		20, 589, 072	49
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I)	1, 458, 822	50
. 00	Exception payment for inpatient program capital (Wkst. L, P	Pt. III, see instructions)		0	51
. 00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions)		0	
. 00				0	
. 00	Special add-on payments for new technologies			211, 082	
. 01	Islet isolation add-on payment	>		0	
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	•		0	
. 00	Cost of physicians' services in a teaching hospital (see in			0	
. 00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	1
. 00	Ancillary service other pass through costs from Wkst. D, Pt	. IV, COI. II ITHE 200)		28, 896	
. 00	Total (sum of amounts on lines 49 through 58)			22, 287, 872	
. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 min	ous Lino (O)		16, 975 22, 270, 897	
. 00	Deductibles billed to program beneficiaries	ius Title 60)		1, 830, 916	
. 00				11, 872	
. 00	Allowable bad debts (see instructions)			51, 775	
. 00	Adjusted reimbursable bad debts (see instructions)			33, 654	
. 00	, , , , , , , , , , , , , , , , , , , ,	nstructions)		0	1
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		20, 461, 763	
. 00		or applicable to MS-DRGs (see instructions)		
. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96			0	69
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Rural Community Hospital Demonstration Project (§410A Demon	, ,	instructions)	0	
. 87	Demonstration payment adjustment amount before sequestration			0	
. 88	, ,			0	
				_	70
		1		0	
. 90	HSP bonus payment HRR adjustment amount (see instructions)			0	
). 90). 91					
). 90). 91). 92	Bundled Model 1 discount amount (see instructions)			0	
). 89). 90). 91). 92). 93	Bundled Model 1 discount amount (see instructions)			0 31, 276 -5, 098	70

	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0005	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Pre 5/26/2022 12:	pared 56 pm
		Title	: XVIII	Hospi tal	PPS	оо ра
			FFY	(уууу)	Amount	
				0	1. 00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 9
0. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70. 9
0. 98	the corresponding federal year for the period ending on or af Low Volume Payment-3 $$	ter 10/1)			0	
0. 99	HAC adjustment amount (see instructions)				56, 347	
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			20, 431, 594	
1. 01	Sequestration adjustment (see instructions)				0	
1. 02	Demonstration payment adjustment amount after sequestration				0	
	Sequestration adjustment-PARHM pass-throughs				10 707 (4(71. (
	Interim payments Interim payments-PARHM				19, 737, 646	72.0
3. 00	Tentative settlement (for contractor use only)				0	73.0
3. 00	Tentative settlement-PARHM (for contractor use only)				U	73.0
4. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0	12 72 and			693. 948	
	73)	72, 72, and			073, 740	
4. 01	Balance due provider/program-PARHM (see instructions)				244 455	74. (
5. 00	Protested amounts (nonallowable cost report items) in accorda	ince with			244, 455	75.0
	CMS Pub. 15-2, chapter 1, §115.2 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	1		0	90.
0. 00	plus 2.04 (see instructions)	01 2.00			0	/0.
1. 00	Capital outlier from Wkst. L. Pt. I. line 2				0	91.
	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	
	Capital outlier reconciliation adjustment amount (see instruc				0	93.
4. 00	The rate used to calculate the time value of money (see instr	ructions)			0.00	94.
5.00	Time value of money for operating expenses (see instructions)				0	95.
6.00	Time value of money for capital related expenses (see instruc	ctions)			0	96. (
				Pri or to 10/1 1.00	0n/After 10/1 2.00	
	HSP Bonus Payment Amount					
നന നന					_	
	HSP bonus amount (see instructions)			0	0	100.
	HVBP Adjustment for HSP Bonus Payment					
01. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions))		0. 0000000000	0. 0000000000	101.
01. 00 02. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	ns)			0. 0000000000	100. (101. (102. (
01. 00 02. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	ns)		0. 0000000000	0. 0000000000	101. 102.
01. 00 02. 00 03. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	,		0.0000000000	0. 0000000000 0	101. 102. 103.
01. 00 02. 00 03. 00 04. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	5)	ustment	0. 0000000000	0. 0000000000 0	101. 102. 103.
01. 00 02. 00 03. 00 04. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst	s) ration) Adj		0.0000000000	0. 0000000000 0 0. 0000 0	101. 102. 103. 104.
01. 00 02. 00 03. 00 04. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe	s) ration) Adj		0.0000000000	0. 0000000000 0 0. 0000 0	101. 102. 103. 104.
01. 00 02. 00 03. 00 04. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst	s) ration) Adj		0.0000000000	0. 0000000000 0 0. 0000 0	101. 102. 103. 104.
01. 00 02. 00 03. 00 04. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	s) ration) Adji eriod under		0.0000000000	0. 0000000000 0 0. 0000 0	101. 102. 103. 104.
01. 00 02. 00 03. 00 04. 00 00. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	s) ration) Adji eriod under		0.0000000000	0. 0000000000 0 0. 0000 0	101. 102. 103. 104. 200.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin	s) ration) Adji eriod under		0.0000000000	0. 000000000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202.
01. 00 02. 00 03. 00 04. 00 00. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions)	ration) Adjuration) Adjuriod under	the 21st	0. 0000000000	0. 000000000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	ration) Adjuration) Adjuriod under	the 21st	0. 0000000000	0. 000000000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	ration) Adjuration) Adjuriod under	the 21st	0. 0000000000	0. 000000000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	ration) Adjuration) Adjuriod under	the 21st	0. 0000000000	0. 000000000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) 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)	ration) Adji ration) Adji eriod under ne 49)	the 21st	0. 0000000000	0. 000000000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) 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	ration) Adju ration) Adju eriod under ne 49) n first year	the 21st	0. 0000000000	0. 000000000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) 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	ration) Adjustriod under ne 49) a first year ructions)	the 21st	0. 0000000000	0. 000000000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00 08. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjustment factor (see instructions) Medicare inpatient routine cost cap (line 202 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,	ration) Adjustriod under ne 49) a first year ructions)	the 21st	0. 0000000000	0. 000000000 0 0. 0000 0	101.1 102.1 103.1 104.1 200.1 201.1 202.2 203.1 204.1 206.1 207.2 208.1
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 022. 00 033. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) 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)	ration) Adjustriod under ne 49) a first year ructions)	the 21st	0. 0000000000	0. 0000000000 0 0. 00000 0 0. otration	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209.
01. 00 02. 00 04. 00 04. 00 00. 00 01. 00 02. 00 033. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) 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	ration) Adjustion and Adjustion and Adjustion and Adjustion and Adjustion and Adjustic and Adjus	the 21st	0. 0000000000	0. 0000000000 0 0. 0000 0 0. otration	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210.
01. 00 02. 00 04. 00 04. 00 00. 00 01. 00 02. 00 033. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) 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)	ration) Adjustion and Adjustion and Adjustion and Adjustion and Adjustion and Adjustic and Adjus	the 21st	0. 0000000000	0. 0000000000 0 0. 0000 0 0. otration	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00 011. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) 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	ration) Adjustriod under the 49) a first year tructions) line 59)	the 21st	0. 0000000000	0. 0000000000 0 0. 00000 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 211.
01. 00 02. 00 033. 00 04. 00 00. 00 01. 00 022. 00 033. 00 04. 00 06. 00 07. 00 08. 00 09. 00 10. 00 11. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) 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 Total adjustment to Medicare Part A IPPS payments (from line	ration) Adjustriod under the 49) a first year tructions) line 59)	the 21st	0. 0000000000	0. 0000000000 0 0. 00000 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 206. 207. 208. 209. 210. 211.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00 11. 00 11. 00 11. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) 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	ration) Adjuration) Adjuration Ad	of the curre	0. 0000000000	0. 0000000000 0 0. 00000 0 0. tration	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 211.

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2021 Part A Exhi bit 4 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 12:56 pm Provider CCN: 15-0005

					10	7 12/31/2021	5/26/2022 12:	
		lw (0 5 5			XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After	Total (Col 2 through 4)	
		Title	E, Part A)	EIILI LI ellleiil	10 10/01	10/01	tili ough 4)	
		0	1. 00	2. 00	3.00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1.00
4 04	payments	1 01	40 (04 7(0		40 (04 7(0		40 (04 7(0	4 04
1. 01	DRG amounts other than outlier payments for discharges	1. 01	12, 631, 760	0	12, 631, 760		12, 631, 760	1. 01
	occurring prior to October 1							
1. 02	DRG amounts other than outlier	1. 02	4, 312, 783	0		4, 312, 783	4, 312, 783	1. 02
	payments for discharges							
	occurring on or after October							
1. 03	DRG for Federal specific	1. 03	0	0	0		0	1.03
	operating payment for Model 4							
	BPCI occurring prior to							
1. 04	October 1 DRG for Federal specific	1. 04	0	0		0	0	1. 04
1.01	operating payment for Model 4	1.01	J	J		J		1.01
	BPCI occurring on or after							
2. 00	October 1 Outlier payments for	2. 00						2.00
2.00	discharges (see instructions)	2.00						2.00
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
2.02	discharges for Model 4 BPCI Outlier payments for	2.02	700 (50		700 /50		700 (50	2.00
2. 02	discharges occurring prior to	2. 03	798, 658	0	798, 658		798, 658	2. 02
	October 1 (see instructions)							
2. 03	Outlier payments for	2. 04	229, 373	0		229, 373	229, 373	2. 03
	discharges occurring on or after October 1 (see							
	instructions)							
3. 00	Operating outlier	2. 01	0	0	0	0	0	3.00
	reconciliation	0.00						
4. 00	Managed care simulated payments	3. 00	0	O	0	O	0	4.00
	Indirect Medical Education Adj	ustment						
5. 00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	0	0	6.00
0.00	instructions)	22.00	U	U	U	U	0	0.00
6. 01	IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see							
	instructions) Indirect Medical Education Adj	ustment for the	Add-on for Se	ection 422 of t	the MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7.00
	(see instructions)			_				
8. 00	IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
	for managed care (see						_	
0.00	instructions)	20.00			0	0		0.00
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	U	0	9. 00
9. 01	Total IME payment for managed	29. 01	0	0	0	0	0	9. 01
	care (sum of lines 6.01 and							
	8.01) Disproportionate Share Adjustm	ont						
10. 00	Allowable disproportionate	33. 00	0. 0614	0. 0614	0. 0614	0. 0614		10.00
	share percentage (see							
11 00	instructions) Disproportionate share	24.00	240,000	0	102 000	// 201	240.000	11 00
11. 00	adjustment (see instructions)	34. 00	260, 099	0	193, 898	66, 201	260, 099	11.00
11. 01	Uncompensated care payments	36. 00	2, 356, 399		1, 787, 176	569, 223	2, 356, 399	11. 01
4	Additional payment for high pe		RD beneficiary					
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	12.00
13. 00	Subtotal (see instructions)	47. 00	20, 589, 072	0	15, 411, 492	5, 177, 580	20, 589, 072	13.00
14. 00	Hospital specific payments	48. 00	0	o	0	0	0	14. 00
	(completed by SCH and MDH,							
	small rural hospitals only.) (see instructions)							
15. 00	Total payment for inpatient	49. 00	20, 589, 072	0	15, 411, 492	5, 177, 580	20, 589, 072	15.00
	operating costs (see		.,, -, -,		.,,	.,, 200	.,, 3,2	
	instructions)							

LOW VO	LUME CALCULATION EXHIBIT 4				CN: 15-0005	Period: From 01/01/2021 To 12/31/2021	5/26/2022 12:	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	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	1, 458, 822	O	1, 098, 90	359, 921	1, 458, 822	16.00
	Special add-on payments for new technologies	54. 00	211, 082	О	113, 93	97, 151	211, 081	
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0		0 0	0	17. 01 17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		O	0		0 0	О	18. 00
19.00	SUBTOTAL			0	16, 624, 32	5, 634, 652	22, 258, 975	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	1. 00 1. 01	1, 275, 742 0	0	1	319, 341 0 0	1, 275, 742 0	1
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	128, 861 0	0	1,	27, 008 0 0	128, 861 0	21. 00 21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.000	0. 0000		22.00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	О	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0425	0. 0425	0. 042	0. 0425		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	54, 219	0	40, 64	13, 572	54, 219	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 458, 822	0	1, 098, 90	359, 921	1, 458, 822	26. 00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0.00000	0.000000	0	27. 00 28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	o	29. 00
100. 00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

	AL ACQUIRED CONDITION (IAC) REDUCTION CALCULA	ATTON EXHIBIT S		<u>-</u>	From 01/01/2021 To 12/31/2021	Part A Exhi bi Date/Ti me Pre 5/26/2022 12:	epared:	
				XVIII	Hospi tal	PPS		
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
		0	1.00	2. 00	3. 00	4. 00		
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	12, 631, 760	12, 631, 760		12, 631, 760	1. 00 1. 01	
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	4, 312, 783		4, 312, 783	4, 312, 783	1. 02	
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	(0	1. 03	
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04	
2. 00	Outlier payments for discharges (see instructions)	2. 00					2. 00	
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	(0	0	2. 01	
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	798, 658	798, 658	3	798, 658	2. 02	
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)		229, 373		229, 373	229, 373	2. 03	
3. 00	Operating outlier reconciliation	2. 01	0	(0	3.00	
4. 00	Managed care simulated payments	3. 00	0		0	0	4.00	
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000		5. 00	
6. 00	IME payment adjustment (see instructions)	22. 00	0	(ol	0	6. 00	
6. 01	IME payment adjustment for managed care (see instructions)		0	(0	0	6. 01	
	Indirect Medical Education Adjustment for the	e Add-on for S	ection 422 of	the MMA				
7. 00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00	
0.00	instructions)	20.00		,		0	0.00	
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0			0	8. 00 8. 01	
0.01	care (see instructions)	20.01		`		O	0.01	
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	(o	0	9.00	
9. 01	Total IME payment for managed care (sum of	29. 01	0	(0	0	9. 01	
	lines 6.01 and 8.01)							
10. 00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33. 00	0. 0614	0. 0614	0.0614		10.00	
10.00	(see instructions)	33.00	0.0614	0.0014	0.0014		10.00	
11. 00	Disproportionate share adjustment (see instructions)	34. 00	260, 099			260, 099	11.00	
11. 01	Uncompensated care payments	36. 00	2, 356, 399	1, 787, 176	5 569, 223	2, 356, 399	11. 01	
12. 00	Additional payment for high percentage of ESI Total ESRD additional payment (see	46.00	di scharges 0	Γ ,	ol ol	0	12.00	
12.00	instructions)	46.00	0			U	12.00	
13.00	Subtotal (see instructions)	47. 00	20, 589, 072	15, 411, 492	5, 177, 580	20, 589, 072	13.00	
14.00	Hospital specific payments (completed by SCH	48. 00	0	(0	0	14.00	
	and MDH, small rural hospitals only.) (see							
15. 00	instructions) Total payment for inpatient operating costs	49. 00	20, 589, 072	15, 411, 492	5, 177, 580	20, 589, 072	15. 00	
16. 00	(see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	1, 458, 822	1, 098, 90 ⁻	359, 921	1, 458, 822	16. 00	
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	211, 082	113, 93 ⁻	97, 151	211, 082	17. 00 17. 01	
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	(0	0		
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	(0	0	18. 00	
19. 00	SUBTOTAL			16, 624, 324	5, 634, 652	22, 258, 976	19. 00	

	Financial Systems	HENDRI CKS REGI				u of Form CMS-	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5		F	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibi Date/Time Pre 5/26/2022 12:	pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4. 00	
20.00	Capital DRG other than outlier	1. 00	1, 275, 742	956, 401	319, 341	1, 275, 742	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	128, 861	101, 853	27, 008	128, 861	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(0	0	1
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.0000	0. 0000		22.00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	(0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0425	0. 0425	0. 0425		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	54, 219	40, 647	13, 572	54, 219	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 458, 822	1, 098, 90°	359, 921	1, 458, 822	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4. 00	
27.00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	0	(0	
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	
30.00	HVBP payment adjustment (see instructions)	70. 93	31, 276	31, 276	0	31, 276	
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-5, 098	-5, 098	0	-5, 098	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	(0	0	31.01

0 70. 99

32.00 HAC Reduction Program adjustment (see instructions)
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

1.00

2.00

0

3. 00

56, 347

(Amt. to Wkst. E, Pt.

A) 4.00 56,347

32.00

100.00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 12:56 pm

		Title XVIII	Hospi tal	5/26/2022 12: PPS	56 pm
		THE SALL	110061 tu		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1. 00	Medical and other services (see instructions)			13, 455	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions)	ı		30, 435, 018	1
3.00	OPPS payments			24, 033, 777	
4.00	Outlier payment (see instructions)			375, 105	4.00
4. 01	Outlier reconciliation amount (see instructions)	_		0	
5.00	Enter the hospital specific payment to cost ratio (see instructions	;)		0.000	
6.00	Line 2 times line 5			0 00	
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, co	ol 13 line 200		50, 958	1
10.00	Organ acquisitions	7. 10, 11110 200		0	1
11.00	Total cost (sum of lines 1 and 10) (see instructions)			13, 455	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
	Ancillary service charges	2)		44, 603	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69 Total reasonable charges (sum of lines 12 and 13)	')		0 44, 603	
14.00	Customary charges			44, 003	14.00
15. 00	Aggregate amount actually collected from patients liable for paymen	nt for services on	a charge basis	0	15.00
	Amounts that would have been realized from patients liable for paym			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		Ü		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	Total customary charges (see instructions)			44, 603	
19. 00	Excess of customary charges over reasonable cost (complete only if	line 18 exceeds li	ne 11) (see	31, 148	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete only if	line 11 evceeds li	ne 18) (see	0	20.00
20.00	instructions)	TITIC TI CACCCUS TI	1110 10) (300		20.00
21.00	Lesser of cost or charges (see instructions)			13, 455	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instruction	ons)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			24, 459, 840	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAU soo inst	cuctions)	0 4, 397, 846	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus t			20, 075, 449	1
27.00	instructions)	THE SAME OF TITLES 22	20] (300	20,070,117	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50))		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			20, 075, 449	1
	Primary payer payments			1, 183	
32.00	Subtotal (line 30 minus line 31)			20, 074, 266	32.00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			199, 682	
	Adjusted reimbursable bad debts (see instructions)			129, 793	1
	Allowable bad debts for dual eligible beneficiaries (see instructio	ons)		106, 692	
37.00	Subtotal (see instructions)			20, 204, 059	37.00
38. 00	MSP-LCC reconciliation amount from PS&R			0	38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
39. 97	Demonstration payment adjustment amount before sequestration	udaa (aaa laatau	a+! ana)	0	
39. 98 39. 99	Partial or full credits received from manufacturers for replaced de RECOVERY OF ACCELERATED DEPRECIATION	vices (see instruc	Ctions)	0	
	Subtotal (see instructions)			20, 204, 059	1
	Sequestration adjustment (see instructions)			20, 204, 039	
	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs				40. 03
	Interim payments			20, 217, 613	41.00
41. 01	Interim payments-PARHM				41.01
42.00	Tentative settlement (for contractors use only)			0	
	Tentative settlement-PARHM (for contractor use only)			40 55.	42.01
43. 00 43. 01	Balance due provider/program (see instructions)			-13, 554	1
	Balance due provider/program-PARHM (see instructions)	th CMS Dub 15_2	chanter 1	0	43. 01 44. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance wi §115.2	11 OWS FUD. 13-Z,	σιαρισι Ι,		44.00
	TO BE COMPLETED BY CONTRACTOR				1
				0	90.00
90.00	Original outlier amount (see instructions)				1
				0	
91. 00 92. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0. 00	92.00
91. 00 92. 00 93. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0.00	92.00

| Peri od: | Worksheet E-1 | From 01/01/2021 | Part I | Date/Time Prepared: | To 12/31/2021 | Date/Time Prep

				0 12/31/2021	5/26/2022 12:	
		Title	XVIII	Hospi tal	PPS	oo piii
		I npati er	it Part A	Par	t B	
				(11)		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1. 00	Total interim payments paid to provider	1.00	2. 00 19, 690, 995	3. 00	4. 00 20, 020, 032	1. 00
2. 00	Interim payments payable on individual bills, either		19, 690, 995		20, 020, 032	2.00
2.00	submitted or to be submitted to the contractor for					2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2021	46, 651	12/31/2021	197, 581	3. 01
3. 02			()	0	3. 02
3.03)	0	3. 03
3.04			(0	3. 04
3. 05			()	0	3.05
0 50	Provi der to Program		1			0.50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM				0	3. 50 3. 51
3. 51						3.51
3. 53						3.52
3. 54						3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		46, 651		197, 581	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		19, 737, 646		20, 217, 613	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after		I			5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(0	5. 01
5. 02			(0	5.02
5. 03	Provider to Program)	0	5.03
5. 50	TENTATI VE TO PROGRAM)	0	5.50
5. 51	TENTITY E TO TROOM WIT					5. 51
5. 52)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		()	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6.00
4 01	the cost report. (1) SETTLEMENT TO PROVIDER		402.046	,	0	6. 01
6. 01 6. 02	SETTLEMENT TO PROGRAM		693, 948		13, 554	6.01
7. 00	Total Medicare program liability (see instructions)		20, 431, 594		20, 204, 059	7.00
	1. otal mod. od. o program readerity (300 mot. dotrons)		20, 101, 07-	Contractor	NPR Date	7.50
				Number	(Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor			ļ		8.00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2022 12:56 pm

			0 12/31/2021	5/26/2022 12:	56 pm
		Title XIX	Hospi tal	Cost	p
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		1, 912, 711		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1, 912, 711	0	4.00
5.00	Inpatient primary payer payments		O		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1, 912, 711	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				Ī
	Reasonable Charges				1
8.00	Routi ne servi ce charges		2, 999, 790		8.00
9.00	Ancillary service charges		4, 119, 865	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		7, 119, 655	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis				
14. 00	Amounts that would have been realized from patients liable for		0	0	14.00
	a charge basis had such payment been made in accordance with 42	2 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	
16.00	Total customary charges (see instructions)	1611	7, 119, 655	0	
17. 00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	5, 206, 944	0	17.00
10.00	line 4) (see instructions)			0	10 00
18. 00	Excess of reasonable cost over customary charges (complete only 16) (see instructions)	y II ITHE 4 exceeds ITHE	٩	0	18. 00
19. 00	Interns and Residents (see instructions)			0	19.00
	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 10		1, 912, 711	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				21.00
22.00	Other than outlier payments		T 0	0	22. 00
	Outlier payments		o	0	
	Program capital payments		o		24.00
	Capital exception payments (see instructions)		o		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		o	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		o	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1, 912, 711	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1, 912, 711	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		31, 046	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review		0		35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	1, 881, 665	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		1, 881, 665	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
	Total amount payable to the provider (sum of lines 38 and 39)		1, 881, 665	0	
41.00	Interim payments		2, 728, 389	0	
42.00	Balance due provider/program (line 40 minus line 41)		-846, 724	0	
43.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2		1		I

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

Health Financial Systems

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

Provider CCN: 15-0005 | Period: From 01/01/

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 12:56 pm

UIII y)					5/26/2022 12:	56 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1, 00	2.00	0.00	11.00	
1.00	Cash on hand in banks	9, 730, 849	1	0	0	
2.00	Temporary investments	0	0	0		1
3.00	Notes receivable	0	0	0	1	3.00
4. 00 5. 00	Accounts receivable Other receivable	171, 392, 812	0	0	0	4. 00 5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-144, 794, 862		0	0	
7. 00	Inventory	4, 107, 147	1	0	l ő	7.00
8.00	Prepai d expenses	0	0	0	0	
9.00	Other current assets	45, 237, 221	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	
11. 00	Total current assets (sum of lines 1-10)	85, 673, 167	0	0	0	11.00
12 00	FIXED ASSETS Land	0	ol	0	0	12.00
12. 00 13. 00	Land improvements	0	0	0	1	12. 00 13. 00
14. 00	Accumul ated depreciation	-247, 411, 215	_	0	•	14.00
15. 00	Bui I di ngs	482, 575, 504	1	0		15.00
16.00	Accumulated depreciation	0	0	0	0	
17. 00	Leasehold improvements	0	0	0	0	17.00
18. 00	Accumulated depreciation	0	0	0	0	18. 00
19. 00	Fi xed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21. 00 22. 00	Automobiles and trucks Accumulated depreciation	0	0	0	0	21. 00 22. 00
23. 00	Major movable equipment	1, 624, 593	_	0	0	23.00
24. 00	Accumulated depreciation	1,024,379		0	Ö	24.00
25. 00	Mi nor equi pment depreci abl e	0	Ö	0	l ő	25.00
26.00	Accumulated depreciation	O	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	236, 788, 882	0	0	0	30.00
31. 00	OTHER ASSETS Investments	330, 128, 909	0	0	0	31.00
32. 00	Deposits on Leases	0 0 0		0	1	32.00
33. 00	Due from owners/officers	12, 544, 164	Ö	0	Ō	33.00
34.00	Other assets	25, 782, 905	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	368, 455, 978	1	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	690, 918, 027	0	0	0	36.00
27.00	CURRENT LI ABI LI TI ES	10.052.7/5		0		27.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	18, 953, 765 12, 045, 398	1	0	•	37. 00 38. 00
39. 00	Payrol I taxes payable	12, 043, 370		0	0	
40.00	Notes and Loans payable (short term)	19, 235, 000	Ö	0	Ö	
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	13, 659, 411				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	25, 013, 709	1	0	0	1
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	88, 907, 283	0	0	0	45.00
46. 00	Mortgage payable	101, 757, 048	ol	0	0	46.00
47. 00	Notes payable	101, 737, 048		0	1	
48. 00	Unsecured Loans	Ö	Ö	0		
49.00	Other long term liabilities	14, 065, 881	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	115, 822, 929	0	0		50.00
51.00	Total liabilities (sum of lines 45 and 50)	204, 730, 212	0	0	0	51.00
F0 00	CAPITAL ACCOUNTS	10/ 107 015	1			
52. 00 53. 00	General fund balance	486, 187, 815	0			52.00
54.00	Specific purpose fund Donor created - endowment fund balance - restricted		١	0		53. 00 54. 00
55. 00	Donor created - endowment fund balance - restricted		•	0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			9	0	57.00
58.00	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	486, 187, 815	1	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	690, 918, 027	0	0	0	60.00
	J 7 /	ļ	ı l		i	I

| In Lieu of Form CMS-2552-10 | Period: From 01/01/2021 | Worksheet G-1

					From 01/01/2021 To 12/31/2021		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1. 00	2.00	3.00	4. 00	5. 00	
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		447, 698, 284 38, 489, 531		(1. 00 2. 00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	486, 187, 815		0	0	3. 00 4. 00
5. 00 6. 00		0			0	0	6. 00
7. 00 8. 00		0			0	0	
9. 00 10. 00	Total additions (sum of line 4-9)	0	0		0	0	9. 00 10. 00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	486, 187, 815		0	0	
13. 00 14. 00		0			0	0	14. 00
15. 00 16. 00		0			0	0 0	16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)	0	0		0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	F. I	486, 187, 815		()	19. 00
		Endowment Fund	PI ant	Funa			
		6. 00	7. 00	8. 00			
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0		1. 00 2. 00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0		3. 00 4. 00
5. 00 6. 00			0				5. 00 6. 00
7. 00 8. 00			0				7. 00 8. 00
9. 00 10. 00	Total additions (sum of line 4-9)	0	0		0		9.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0		0		11.00
13. 00 14. 00 15. 00			0				13. 00 14. 00 15. 00
16. 00 17. 00			0				16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	O		0		18. 00 19. 00
	•						

| Peri od: | Worksheet G-2 | From 01/01/2021 | Parts | & II | To | 12/31/2021 | Date/Time | Prepared: Health Financial Systems HI STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0005

Cost Center Description				Го 12/31/2021	Date/Time Pre 5/26/2022 12:	
PART I - PATIENT REVENUES 1.00 2.00 3.00		Cost Center Description	I npati ent	Outpati ent		ос р
PART I - PATENT REVENUES Secretar Inpatient Routine Services 1.00 Hospi tal Services 1.00 Hospi tal Services 1.00 Susprævujer - IPF Susprævujer - IPP Susprævuje						
1.00 Hospital		PART I - PATIENT REVENUES	•			
2.00 SUBPROVIDER - IPF 2.00 3.0		General Inpatient Routine Services				
3.00 SUBPROVIDER - IRF	1.00	Hospi tal	64, 824, 270	D	64, 824, 270	1.00
SUBPROVIDER	2.00	SUBPROVI DER - I PF				2.00
South Sout	3.00	SUBPROVI DER - I RF				3.00
Solid Swing Bod NF	4.00	SUBPROVI DER				4.00
7. 00 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0	5.00	Swing bed - SNF			0	5.00
8. 00 NURSING FACILITY 0,00 0.00 Total general inpatient care services (sum of lines 1-9) 64,824,270 64,824,270 10.00 1.00	6.00	Swing bed - NF			0	6.00
9. 00 10. 00 THER LONG TERM CARE 10. 00 Total general inpatient care services (sum of lines 1-9) 10. 00 Total general inpatient care services (sum of lines 1-9) 11. 00 Total general inpatient Hospital Services 11. 00 Total general inpatient Foreign Services 11. 00 Total general inpatient Foreign Services 12. 00 Total general inpatient Foreign Services 13. 00 Total general inpatient Foreign Services 14. 512, 989 14. 512, 989 16. 00 Total general inpatient Foreign Services (sum of lines 10 and 16) 17. 00 Total general general General Services (sum of lines 10 and 16) 18. 00 Total general general General Services (sum of lines 10 and 16) 19. 00 Unpatient services 153. 856, 504 19. 00 Total general G	7.00	SKILLED NURSING FACILITY			0	7.00
10. 0	8.00	NURSING FACILITY				8.00
Intensive Care Type Inpati ent Hospital Services	9.00	OTHER LONG TERM CARE				9.00
Intensive Care Type Inpatient Hospital Services	10.00	Total general inpatient care services (sum of lines 1-9)	64, 824, 270		64, 824, 270	10.00
12. 00 CORONARY CARE UNIT SURN INTENSIVE CARE UNIT SURKI ICAL INTENSIVE CARE UNIT 14. 00 13. 00 14. 00 15. 00 00 00 00 14. 512, 989 14. 512, 989 16. 00 17. 00 1						
13.00 BURN INTENSIVE CARE UNIT	11.00	INTENSIVE CARE UNIT	14, 512, 989	9	14, 512, 989	11.00
14. 00 SURGICAL INTENSIVE CARE UNIT 14. 512, 989 14. 512, 989 15. 00 10. 101 101	12.00	CORONARY CARE UNIT				12.00
15. 00 OTHER SPECIAL CARE (SPECIFY) 16. 00 Total intensive care type inpatient hospital services (sum of lines 114,512, 989 114,512, 989 15. 00 11-15) 17. 00 Total inpatient routine care services (sum of lines 10 and 16) 19. 00 Outpatient services 19. 00 Outpatient services 19. 00 Outpatient services 19. 00 OWNER HEALTH CLINIC 19. 00 OWNER HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 23. 00 AWNERLANDER SERVICES 24. 00 CMC 25. 00 HOSPICE 27. 00 PRO FEES 29. 00 OWNER SERVICES 29. 00 OWNER Till - OPERATING EXPENSES 29. 00 OWNER Till - OWNER	13.00	BURN INTENSIVE CARE UNIT				13.00
16. 00 Total intensive care type inpatient hospital services (sum of lines 11.4, 512, 989 14, 512, 989 17, 00 17, 00 10 10 10 10 10 10 10	14.00	SURGICAL INTENSIVE CARE UNIT				14.00
16. 00 Total intensive care type inpatient hospital services (sum of lines 11.4, 512, 989 14, 512, 989 17, 00 17, 00 10 10 10 10 10 10 10	15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
11-15	16.00		14, 512, 989	9	14, 512, 989	16.00
18.00 Ancillary services 153,856,504 826,765,224 980,621,728 18.00 19.00 0 0 93,993 93,993 19.00 20.00 0 0 0 0 0 0 0 0 0						
19.00 Outpatient services 0 93,993 93,993 19.00 20.00 RURAL HEALTH CLINIC 0 0 0 0 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 21.00 22.00 HOME HEALTH AGENCY 22.00 24.00 CMHC 24.00 24.00 25.00 AMBULATORY SURGICAL CENTER (D.P.) 26.00 CMHC 27.00 2	17.00	Total inpatient routine care services (sum of lines 10 and 16)	79, 337, 259	9	79, 337, 259	17.00
20. 00 RURÂL HEALTH CLINIC 0 0 0 0 0 20. 00 21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 21. 00 22. 00 HOME HEALTH AGENCY 23. 00 23. 00 AMBULANCE SERVICES 23. 00 24. 00 CMHC 24. 00 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 25. 00 26. 00 HOSPICE 2, 210, 900 1, 738, 914 3, 949, 814 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 235, 404, 663 828, 598, 131 1, 064, 002, 794 27. 00 PART II - OPERATING EXPENSES 2, 210, 900 1, 738, 914 3, 949, 814 29. 00 ADD (SPECIFY) 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 0 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 40. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 385, 634, 417 43. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 385, 634, 417 43. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 385, 634, 417 43. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 385, 634, 417 43. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 385, 634, 417 43. 00 44. 00	18.00	Ancillary services	153, 856, 504	826, 765, 224	980, 621, 728	18.00
21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 21. 00 22. 00 0 0 22. 00 0 0 22. 00 0 0 22. 00 0 0 22. 00 0 0 0 22. 00 0 0 0 22. 00 0 0 0 0 0 23. 00 0 0 0 24. 00 0 0 0 0 0 0 24. 00 0 0 0 0 0 0 0 0 0	19.00	Outpatient services		93, 993	93, 993	19.00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 29. 00 29. 00 20	20.00	RURAL HEALTH CLINIC		0	0	20.00
23. 00	21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
24. 00 25. 00 AMBULATORY SURGICAL CENTER (D. P.) 26. 00 HOSPICE PRO FEES 2, 210, 900 1, 738, 914 3, 949, 814 27. 00 28. 00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1) PART II - OPERATING EXPENSES 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 24. 00 25. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 27. 00 28. 00 38. 634, 417 29. 00 385, 634, 417 29. 00 30. 00 31. 00 31. 00 32. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00 41. 00 42. 00 43. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 385, 634, 417 24. 00 25. 00 26. 00 26. 00 26. 00 27. 00 382, 598, 131 1, 738, 914 3, 949, 814 27. 00 28. 00 385, 634, 417 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00 41. 00 41. 00 42. 00 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 385, 634, 417 43. 00	22.00	HOME HEALTH AGENCY				22.00
25. 00 26. 00 26. 00 27. 00 28. 00 29. 00 20	23.00	AMBULANCE SERVICES				23.00
26. 00 27. 00 27. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 39. 00 39. 00 39. 00 39. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 30	24.00	CMHC				24.00
27. 00 PRO FEES 20. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 235, 404, 663	25.00	AMBULATORY SURGICAL CENTER (D. P.)				25.00
28. 00	26.00	HOSPI CE				26.00
28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 235, 404, 663 828, 598, 131 1,064,002,794 28.00 6-3, line 1)	27.00	PRO FEES	2, 210, 900	1, 738, 914	3, 949, 814	27.00
PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 30.00 ADD (SPECIFY) 0 30.00 31.00 32.00 33.00 0 33.00 34.00 33.00 34.00 35.00 0 35.00 0 35.00 0 35.00 0 37.00 0 36.00 37.00 DEDUCT (SPECIFY) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	235, 404, 663			28.00
29. 00 30. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 39. 00 40. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (per Wkst. A, column 3, line 200) 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 385, 634, 417 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 385, 634, 417 385, 634, 417		G-3, line 1)				
30.00 31.00 31.00 32.00 31.00 32.00 32.00 33.00 32.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 35.00 35.00 35.00 36.00 Total additions (sum of lines 30-35) 0 36.00 37.00 38.00 37.00 38.00 39.00 40.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 70 10 10 10 10 10 10 10 10 10 10 10 10 10		PART II - OPERATING EXPENSES				
31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 31.00 0 32.00 33.00 33.00 33.00 0 33.00 34.00 35.00 0 36.00 0 37.00 0 38.00 0 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 385,634,417 43.00						
32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 32.00 33.00 33.00 34.00 35.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 385,634,417 43.00		ADD (SPECIFY)	1			
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 33.00 0 34.00 0 35.00 0 37.00 0 38.00 0 0 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00						
34.00 35.00 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 34.00 0 35.00 0 36.00 0 37.00 0 38.00 0 0 40.00 41.00 42.00 385,634,417				-		
35.00 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 35.00 0 36.00 37.00 0 37.00 0 38.00 0 39.00 0 41.00 0 42.00 385,634,417						
36.00 Total additions (sum of lines 30-35) 0 36.00 37.00 38.00 39.00 0 39.00 0 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 0 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 385, 634, 417 43.00 36.00 37.00 38.00 38.00 0 39.00 0 40.00 0 41.00 0 41.00 0 42.00 0 42.00 0 43.00 0 0 0 0 0 0 0 0 0						
37.00 DEDUCT (SPECIFY)						
38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 385, 634, 417 43.00				0		
39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 385, 634, 417 380)		DEDUCT (SPECIFY)				
40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 385, 634, 417 43.00			1			
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 385, 634, 417 43.00			1			
42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 385, 634, 417 43.00						
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 385, 634, 417 43.00						
				0		
to Wkst. G-3, line 4)	43. 00		r	385, 634, 417		43.00
		to Wkst. G-3, Tine 4)	I	1		

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10						
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0005 Period:	Worksheet G-3					
From 01/01 To 12/31	1/2021 1/2021 Date/Time Prepared: 5/26/2022 12:56 pm					
	1. 00					
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1, 064, 002, 794 1. 00					
2.00 Less contractual allowances and discounts on patients' accounts	683, 435, 910 2. 00					
3.00 Net patient revenues (line 1 minus line 2)	380, 566, 884 3. 00					
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	385, 634, 417 4. 00					
5.00 Net income from service to patients (line 3 minus line 4)	<u>-5, 067, 533</u> 5. 00					
OTHER I NCOME						
6.00 Contributions, donations, bequests, etc	0 6.00					
7.00 Income from investments	22, 725, 720 7. 00					
8.00 Revenues from telephone and other miscellaneous communication services	0 8.00					
9.00 Revenue from television and radio service	0 9.00					
10.00 Purchase discounts	0 10.00					
11.00 Rebates and refunds of expenses	0 11.00					
12.00 Parking Lot receipts	0 12.00					
13.00 Revenue from Laundry and Linen service	0 13.00					
14.00 Revenue from meals sold to employees and guests	0 14.00					
15.00 Revenue from rental of living quarters	0 15.00					
16.00 Revenue from sale of medical and surgical supplies to other than patients	0 16.00					
17.00 Revenue from sale of drugs to other than patients	0 17.00					
18.00 Revenue from sale of medical records and abstracts	0 18.00					
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)	0 19.00					
20.00 Revenue from gifts, flowers, coffee shops, and canteen	0 20.00					
21.00 Rental of vending machines	0 21.00					
22.00 Rental of hospital space	0 22.00					
23.00 Governmental appropriations	0 23.00					
24.00 OTHER OPERATING INCOME	11, 785, 921 24. 00					
24. 50 COVI D-19 PHE Funding	9, 045, 406 24. 50					
25.00 Total other income (sum of lines 6-24)	43, 557, 047 25. 00					
26.00 Total (line 5 plus line 25)	38, 489, 514 26. 00					
27.00 OTHER EXPENSES	-17 27.00					
28.00 Total other expenses (sum of line 27 and subscripts)	-17 28.00					
29.00 Net income (or loss) for the period (line 26 minus line 28)	38, 489, 531 29. 00					
	·					

Heal th	Financial Systems HENDRICKS REGION	NAL HEALTH	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0005	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre 5/26/2022 12:	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
1 00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier 1,275,742				
1. 00 1. 01	Model 4 BPCI Capital DRG other than outlier			1, 275, 742 0	1
2. 00	· • • • • • • • • • • • • • • • • • • •			128, 861	2.00
2. 01				120,001	1
3. 00				57. 82	
4.00				0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	5.00
6.00				0	6.00
	1.01) (see instructions)				
7. 00				1. 46	7. 00
8. 00	30) (see instructions)			19. 06	8.00
9. 00				20. 52	
10.00				4. 25	
11. 00				11.00	
12. 00	, , , , , , , , , , , , , , , , , , , ,			1, 458, 822	
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00			0		
4.00	, , , , , , , , , , , , , , , , , , , ,		0		
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1. 00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circumstan	ces (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0 0. 00	
4. 00 5. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0.00	
6. 00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	
7. 00	Adjustment to capital minimum payment level for extraordinar	,	x line 6)	0.00	1
8. 00	Capital minimum payment level (line 5 plus line 7)	y 0.1.04000 (1.1.10 E		Ö	
9.00	Current year capital payments (from Part I, line 12, as appl	i cabl e)		0	9. 00
10.00	Current year comparison of capital minimum payment level to	capital payments (line 8	less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L. Part III, line 14)	capital payment (from pr	ior year	0	11.00
12. 00	Net comparison of capital minimum payment level to capital p	avments (line 10 plus li	ne 11)	0	12.00
13. 00	Current year exception payment (if line 12 is positive, ente			ő	
14. 00	Carryover of accumulated capital minimum payment level over			0	
	(if line 12 is negative, enter the amount on this line)				
15.00	Current year allowable operating and capital payment (see in	structions)		0	
16.00				0	
17.00	Current year exception offset amount (see instructions)			l 0	17.00