This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0030 Worksheet S Period: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/26/2022 3:43 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/26/2022 3:43 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.

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

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HENRY COUNTY MEMORIAL HOSPITAL (15-0030) for the cost reporting period beginning 01/01/2021 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 | Dai | rin Brown | 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 | Darin Brown | | | 2 |
| 3 | Signatory Title | CF0 | | | 3 |
| 4 | Date | (Dated when report is electronica | | | 4 |

| | | Title | XVIII | | | |
|-------------------------------|---------|--------|----------|-------|-----------|--------|
| Cost Center Description | Title V | Part A | Part B | HIT | Title XIX | |
| | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| PART III - SETTLEMENT SUMMARY | | | | | | |
| 1.00 Hospi tal | 0 | 8, 197 | -76, 049 | 0 | -100, 876 | 1.00 |
| 2.00 Subprovider - IPF | 0 | 0 | 0 | | 0 | 2.00 |
| 3.00 Subprovider - IRF | 0 | 0 | 0 | | 0 | 3.00 |
| 5.00 Swing Bed - SNF | 0 | 0 | 0 | | 0 | 5.00 |
| 6.00 Swing Bed - NF | 0 | | | | 0 | 6.00 |
| 9. 00 HOME HEALTH AGENCY I | 0 | 0 | 0 | | 0 | 9.00 |
| 10.00 RURAL HEALTH CLINIC I | 0 | | 183, 405 | | 0 | 10.00 |
| 10.01 RURAL HEALTH CLINIC II | 0 | | 325, 874 | | 0 | 10. 01 |
| 10.02 RURAL HEALTH CLINIC III | 0 | | 33, 428 | | 0 | 10.02 |
| 200. 00 Total | 0 | 8, 197 | 466, 658 | 0 | -100, 876 | 200.00 |

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0030 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 3:43 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1000 NORTH 16TH STREET 1.00 PO Box: 1.00 State: IN 2.00 City: NEW CASTLE Zip Code: 47392-County: HENRY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 HENRY COUNTY MEMORIAL 150030 99915 07/01/1996 Ν 0 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA HCMH HOME CARE 157430 99915 06/14/1995 Ρ Ν 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce HOSP-BASED HOSPICE 151564 99915 14.00 08/31/1998 14.00 NEW CASTLE FAMILY AND Hospital-Based Health Clinic - RHC 0 15.00 158520 99915 04/11/2017 N 0 15.00 NTERNAL MED Hospital-Based Health Clinic - RHC NCFIM - NORHTFIELD PARK 158525 99915 15.01 15.01 12/04/2017 0 0 15.02 Hospital -Based Health Clinic - RHC CAMBRIDGE CITY FAMILY 158556 0 99915 06/02/2020 0 15 02 N 1111 HEALTH PARTNER Hospital-Based Health Clinic - FQHC 16.00 Hospital -Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2021 12/31/2021 20.00 21.00 Type of Control (see instructions) 9 21.00 1. 00 2. 00 3. 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22. 01 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν 22.03 Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to N N N 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

| 25. 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. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. | 0 | 0 | 0 | O | | O | | 25.00 |
|--------|---|--|--|--|--------------------------|------|-------|-------|--------|
| | | | | | Urban/R | | | | |
| 24 00 | Enter your standard geographic classification (not w | (aga) status | at the be | ginning of | 1. (| 00 | 2. | 00 | 26. 00 |
| 20.00 | cost reporting period. Enter "1" for urban or "2" fo | | at the be | giriiiriig oi | the | ' | | | 20.00 |
| 27. 00 | Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif | or"2" for r | ural. If a | d of the co pplicable, | st | 1 | | | 27. 00 |
| 35. 00 | If this is a sole community hospital (SCH), enter the effect in the cost reporting period. | | | CH status i | | 0 | | | 35. 00 |
| | | | | | Begi nr | | Endi | | - |
| 36. 00 | Enter applicable beginning and ending dates of SCH s | status. Suhs | script line | 36 for num | 1. (| 0 | 2. | UU | 36.00 |
| | of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente | es. | · | | | 1 | | | 37. 00 |
| 37. 01 | is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f | | | | | | | | 37. 01 |
| 38. 00 | instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. | | | | | | | /2021 | 38.00 |
| | onto. Subsequent action | | | | Y/ | N | Υ/ | 'N | |
| | | | | | 1. (| | 2. | | |
| | Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octono in column 2, for discharges on or after October 1 |), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente | (iii)? En e requireme in column nt? Enter " er "Y" for | ter in colu nts in 2 "Y" for y Y" for yes | ves or N | | Ŋ | | 39.00 |
| | ino Tili Gordanii 27 Toi Greathar goo on or artor corobor i | (000 11.01 | 401. 0.10) | | | V | XVIII | XIX | |
| | | | | | | 1.00 | 2.00 | 3.00 | |
| 4E 00 | Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme | nt for dien | roporti opo | to chara in | accordance | N | l N | N | 45. 00 |
| 45.00 | with 42 CFR Section §412.320? (see instructions) | ant ron ursp | л орог стопа | te share in | accordance | 14 | IN IN | I IN | 45.00 |
| 46. 00 | Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. | | | | | N | N | N | 46.00 |
| | Is this a new hospital under 42 CFR §412.300(b) PPS | | | | | N | N | N | 47.00 |
| 48. 00 | Is the facility electing full federal capital paymen | it? Enter " | Y" for yes | or "N" for | no. | N | N | N | 48. 00 |
| 56. 00 | Teaching Hospitals Is this a hospital involved in training residents in | | | | | r N | | | 56.00 |
| | "N" for no in column 1. For column 2, if the respons was involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or appli Enter "Y" for yes; otherwise, enter "N" for no in co | rograms in cable CRs) | the prior | year or pen | nultimate | | | | |
| | If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. I | period duri or yes or "N oth of this Y", complet | l" for no i cost repor e Workshee | n column 1. ting period | If column I? Enter "Y | | | | 57.00 |
| 58. 00 | If line 56 is yes, did this facility elect cost reim | bursement f | or physici | ans' servic | es as | | | | 58.00 |
| 59. 00 | defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If ye | | | , Pt. I. | | N | | | 59.00 |
| | | | | | | | | | |
| | | | | | | | | | |

| OSPI T | AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA | TA | Provi der CC | CN: 15-0030 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Pre 5/26/2022 3:4 | pared |
|--------|--|--------------------------------|---------------------------------|-----------------------|--|---|-------|
| | | | | NAHE 413.85 Y/N | Worksheet A Line # | Pass-Through Qualification Criterion Code | |
| | | < | | 1.00 | 2. 00 | 3. 00 | |
| 0. 00 | Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent Cadjustement? Enter "Y" for yes or "N" for no in colu | 85? (s umn 1. CR) NAHE | see If column 1 | N | | | 60. |
| | pag de tement. 2.1161 | Y/N | IME | Direct GME | I ME | Direct GME | |
| | | 1.00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| . 00 | Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) | N | | | 0.00 | 0.00 | 61. |
| 1. 01 | Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) | | | | | | 61. |
| . 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. |
| . 03 | Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) | | | | | | 61. |
| . 04 | Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the | | | | | | 61. |
| . 05 | current cost reporting period. (see instructions). 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. |
| . 06 | 61.04 minus line 61.03). (see instructions) 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. |
| | | Pro | gram Name | ram Name Program Code | | Unweighted Direct GME FTE Count | |
| 10 | 06.11575 | | 1. 00 | 2. 00 | 3. 00 | 4.00 | (1 |
| . 10 | Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. | | | | 0.00 | 0. 00 | 01. |
| . 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, | | | | 0.00 | 0. 00 | 61. |
| | the direct GME FTE unweighted count. | | | | | | |
| | | | | | | 1.00 | |
| 00 | ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital | | | | eriod for which | 0.00 | 62 |
| | 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 | tions) ı Teachi ıram. (s | ng Health Cen see instructio | iter (THC) in | | 0. 00 | |
| | Teaching Hospitals that Claim Residents in Nonprovide | | | • | | | 1 |

| Health Financial Systems | | HENRY COU | NTY MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--|--|--|--|---------------------------|--|--|---|---------|
| HOSPITAL AND HOSPITAL HEALTH CA | ARE COMPLEX | | | Provi der CC | Fr | eriod: com 01/01/2021 o 12/31/2021 | Worksheet S-2 Part I Date/Time Pre 5/26/2022 3:4 | pared: |
| | | | | | Unwei ghted FTEs Nonprovi der Si te | Unwei ghted FTEs in Hospi tal | Ratio (col. 1/ (col. 1 + col. 2)) | |
| | | | | | 1.00 | 2. 00 | 3. 00 | |
| Section 5504 of the ACA period that begins on or 64.00 Enter in column 1, if lii in the base year period, resident FTEs attributab | after July ne 63 is ye the number le to rotat | 1, 2009 and beforms, or your facilication of unweighted no ions occurring in | ty trained n-primary all nonpr | resi dents care | O. 00 | | | 64. 00 |
| settings. Enter in colu resident FTEs that train of (column 1 divided by | ed in your | hospital. Enter i | n column 3 | the ratio | | | | |
| | | Program Name | | am Ćode | 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 | |
| 65.00 Enter in column 1, if I is yes, or your facility trained residents in the year period, the program associated with primary caprogram in which you trained the program code. Enter column 3, the number of unweighted primary care residents attributable to rotations occurring in a non-provider settings. Election of unweighted primary care resident FTEs that train your hospital. Enter in 5, the ratio of (column 3 + column 4). (see instructions) | base name care re ined mn 2, in FTE o II nter in ed in column 3 | | | | 0.00 | 0.00 | 0.000000 Ratio (col. | 65.00 |
| | | | | | FTEs Nonprovi der Si te | FTEs in Hospital | 1/ (col. 1 + col. 2)) | |
| 5504 6 11 404 | 0 | FTE Death leader | | L. C. III | 1.00 | 2. 00 | 3.00 | |
| Section 5504 of the ACA beginning on or after Ju | | ir FIE Residents i | n Nonprovi | der Setting | JSETTECTIVE T | or cost report | ing perioas | |
| 66.00 Enter in column 1 the number FTEs attributable to rote Enter in column 2 the number FTEs that trained in you (column 1 divided by | mber of unw ations occu mber of unw r hospital. | rring in all nonp eighted non-prima Enter in column | rovider se ry care re 3 the rati | ttings. sident o of | 0.00 | 0. 00 | 0. 000000 | 66. 00 |
| | | Program Name | | am Code | Unwei ghted FTEs Nonprovi der Si te | Unweighted FTEs in Hospital | Ratio (col. 3/ (col. 3 + col. 4)) | |
| (7.00 Enter in 1.1 1.1 | | 1. 00 | 2 | . 00 | 3.00 | 4. 00 | 5.00 | (7.00 |
| 67.00 Enter in column 1, the pname associated with eacl your primary care prograwhich you trained reside Enter in column 2, the pcode. Enter in column 3, number of unweighted primary care FTE residents attributed to rotations occurring in non-provider settings. Encolumn 4, the number of unweighted primary care resident FTEs that train your hospital. Enter in 5, the ratio of (column 3 + column 4). (see instructions) | h of ms in nts. rogram the mary butable n all nter in ed in column 3 | | | | 0.00 | 0.00 | 0.00000 | 67.00 |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0030 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 3:43 pm 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75 00 N 75 00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 80.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 $\S413.40(f)(1)(ii)$? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90 00 Ν yes or "N" for no in the applicable column. is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Ν 92.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93.00 Ν N 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν N 96.00 applicable column. 97.00 | If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Υ 98.00 stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98.01 C,Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V,and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and N N 98.04 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? 105 00 Ν 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

| Health Financial Systems HENRY COUNTY MEM | | | | u of Form CMS | |
|--|---|---|--|---------------------|--------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provi der CC | | Peri od: From 01/01/2021 To 12/31/2021 | | repared: |
| | | | V | 5/26/2022 3: XIX | 43 pm |
| | | | 1.00 | 2. 00 | |
| 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no. | e CRNA fee sche | edul e? See 42 | 2 N | | 108. 00 |
| | Physi cal 1.00 | Occupati onal | Speech 3.00 | Respiratory 4.00 | , |
| 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. | | N N | N N | N N | 109. 00 |
| | | | | 1.00 | |
| 110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. | "Y" for yes or | "N" for no. | If yes, | N | 110.00 |
| | | | 1.00 | 2. 00 | |
| 111.00 f this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to of integration prong of the FCHIP demo in which this CAH is particled that apply: "A" for Ambulance services; "B" for a for tele-health services. | cost reporting column 1 is Y, articipating 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 Heademonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 in column 2, the date the hospital began participating in demonstration. In column 3, enter the date the hospital coparticipation in the demonstration, if applicable. | g period? is "Y", enter the | N | | | 112.00 |
| Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of | or "N" for no | l N | | | 0115.00 |
| in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either 'for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1. | B, or E only) "93" percent (includes ers) based on | | | | |
| 116.00 s this facility classified as a referral center? Enter "Y" "N" for no. | " for yes or | N | | | 116. 00 |
| 117.00 Is this facility legally-required to carry malpractice insu | urance? Enter | Y | | | 117. 00 |
| 118.00 s the malpractice insurance a claims-made or occurrence pour lif the policy is claim-made. Enter 2 if the policy is occur | | | 1 | | 118. 00 |
| IT the portey is craim-made. Enter 2 if the portey is occur | r ence. | Premi ums | Losses | Insurance | |
| | | | | | |
| | | 1. 00 | 2. 00 | 3. 00 | |
| 118.01 List amounts of malpractice premiums and paid losses: | | 207, 59 | 94 C |) | 0 118. 01 |
| 110.00 | | 46 | 1. 00 N | 2. 00 | 110.00 |
| 118.02 Are mal practice premiums and paid losses reported in a cos- Administrative and General? If yes, submit supporting sche and amounts contained therein. | | | N | | 118. 02 |
| 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments. | in column 1, "Y qualifies for t | /" for yes or the Outpatient | | N | 119. 00 120. 00 |
| Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implements? Enter "Y" for yes or "N" for no. | lantable device | es charged to | Y | | 121. 00 |
| 122.00 Does the cost report contain healthcare related taxes as do Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information | 1 is "Y", ente | | | | 122. 00 |
| 125.00 Does this facility operate a transplant center? Enter "Y" | for yes and "N" | for no. If | N | | 125. 00 |
| yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, or a solution of the so | | fication date | ÷ | | 126. 00 |
| in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en | nter the certif | ication date | | | 127. 00 |
| in column 1 and termination date, if applicable, in column 128.00 of this is a Medicare certified liver transplant center, en | | ication date | | | 128. 00 |
| in column 1 and termination date, if applicable, in column | 2. | | | | |
| 129.00 f this is a Medicare certified lung transplant center, en | ter the certifi | cation date i | nl | | 129.00 |

| Health Financial Systems | HENRY COUNTY MEM | MORIAL HOSPITAL | | | In Lie | u of Form CMS | -2552-10 |
|---|---------------------------|------------------|------------------------|------------|----------------|------------------------|--------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLI | EX IDENTIFICATION DATA | Provi der CC | N: 15-0030 | Peri od: | /01/2021 | Worksheet S- Part I | 2 |
| | | | | | 2/31/2021 | Date/Time Pr | |
| | | | | | | 5/26/2022 3: | 43 pm |
| | | | | | 1. 00 | 2. 00 | |
| 130.00 If this is a Medicare certified p | | | ti fi cati on | | | | 130.00 |
| 131.00 If this is a Medicare certified i | | | erti fi cati on | n | | | 131.00 |
| date in column 1 and termination | | | #: | | | | 122.00 |
| 132.00 If this is a Medicare certified in column 1 and termination date, | | | cation date | | | | 132.00 |
| 133.00 Removed and reserved | | | | | | | 133.00 |
| 134.00 If this is an organ procurement o and termination date, if applicab | | the OPO number i | in column 1 | | | | 134.00 |
| All Providers | | | | | | | |
| 140.00 Are there any related organization chapter 10? Enter "Y" for yes or | | | | | Υ | | 140. 00 |
| are claimed, enter in column 2 th | | | | .5 | | | |
| 1.00 | 2. (| | | | 3. 00 | | |
| If this facility is part of a cha office and enter the home office | | | ugh 143 the | name and | d address | of the home | |
| 141. 00 Name: | Contractor's Name: | actor riambor. | Contract | tor's Nur | mber: | | 141.00 |
| 142.00 Street: 143.00 Ci ty: | PO Box: | | 7i n Code | | | | 142.00 |
| 143. 00 C1 ty: | State: | | Zi p Code | e: | | | 143.00 |
| | | | | | | 1.00 | |
| 144.00 Are provider based physicians' co | sts included in Worksheet | A? | | | | Y | 144.00 |
| | | | | | 1. 00 | 2.00 | - |
| 145.00 If costs for renal services are c | | | | | | | 145. 00 |
| inpatient services only? Enter "Y no, does the dialysis facility in | J | | | | | | |
| period? Enter "Y" for yes or "N" | for no in column 2. | | . 0 | | | | |
| 146.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i | | | | f | N | | 146. 00 |
| yes, enter the approval date (mm/ | | 15-2, Chapter | 40, 94020) I | ' | | | |
| | | | | | | 1.00 | |
| 147.00 Was there a change in the statist | ical basis? Enter "Y" for | ves or "N" for | no. | | | 1. 00 Y | 147. 00 |
| 148.00 Was there a change in the order o | f allocation? Enter "Y" f | or yes or "N" fo | or no. | | | N | 148. 00 |
| 149.00 Was there a change to the simplif | ied cost finding method? | Enter "Y" for ye | es or "N" fo Part B | | tle V | N Title XIX | 149. 00 |
| | | 1.00 | 2. 00 | _ | 3. 00 | 4.00 | - |
| Does this facility contain a prov | ider that qualifies for a | n exemption fro | m the applic | cation o | f the lov | ver of costs | |
| or charges? Enter "Y" for yes or 155.00Hospi tal | "N" for no for each compo | N N | and Part B. | (See 4. | 2 CFR 941 N | N N | 155.00 |
| 156.00 Subprovi der - IPF | | N | N | | N | N | 156. 00 |
| 157. 00 Subprovi der – IRF | | N | N | | N | N | 157.00 |
| 158. 00 SUBPROVI DER 159. 00 SNF | | N | N | | N | N | 158. 00 159. 00 |
| 160.00 HOME HEALTH AGENCY | | N | N | | N | N | 160. 00 |
| 161. 00 CMHC | | | N | | N | N | 161. 00 |
| | | | | | | 1. 00 | |
| Mul ti campus | omnuo hoorital tirilir | no on | | Concert Of | 200 | 8.1 | 1/5 00 |
| 165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. | ampus nosprtar that has o | не ог шоге самр | uses in ditt | erent CE | SAS! | N | 165. 00 |
| | Name | County | | p Code | CBSA | FTE/Campus | |
| 166.00 f line 165 is yes, for each | 0 | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | 0166.00 |
| campus enter the name in column | | | | | | 0.0 | 7.50.00 |
| 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) | | | | | | | |
| | | | | | | 1. 00 | - |
| Health Information Technology (HI | | | | ent Act | | 1.00 | |
| 167.00 Is this provider a meaningful use | | | | | | Y | 167.00 |
| 168.00 If this provider is a CAH (line 1 reasonable cost incurred for the | | | e 16/ is "Y" |), enter | the | | 168. 00 |
| 168.01 If this provider is a CAH and is | not a meaningful user, do | es this provide | | | dshi p | | 168. 01 |
| exception under §413.70(a)(6)(ii) | | | | | nton th | | 00140 00 |
| 169.00 If this provider is a meaningful transition factor. (see instructi | | u is not a CAH | (TITIE TUS ES | s N), € | enter the | 9. 9 | 9169.00 |
| | | | | | | • | |

| Health Financial Systems | HENRY COUNTY MEMOR | In Lie | In Lieu of Form CMS-2552-1 | | | | |
|--|------------------------------|-----------------------|--|---|--------|--|--|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLE | EX IDENTIFICATION DATA | Provider CCN: 15-0030 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Pre 5/26/2022 3:4 | pared: | | |
| | | | | | | | |
| | | | 1. 00 | 2. 00 | | | |
| 170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy) | | | 170. 00 | | | | |
| | | | | | | | |
| | | | 1. 00 | 2.00 | | | |
| 171.00 If line 167 is "Y", does this pro- | vider have any days for indi | ividuals enrolled in | N | 0 | 171.00 | | |
| section 1876 Medicare cost plans | | | | | | | |
| "Y" for yes and "N" for no in col | on | | | | | | |
| 1876 Medicare days in column 2. (| see instructions) | | | | | | |

| Heal th | Financial Systems HENRY COUNTY MEM | IORIAL HOSPITAL | | In Lie | u of Form CMS-: | 2552-10 |
|----------------|--|------------------|----------------------|---|--------------------------|------------------|
| | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider C | CN: 15-0030 F | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | pared: |
| | | | | Y/N | Date | |
| | General Instruction: Enter Y for all YES responses. Enter I | V for all NO r | enoncos Ento | 1.00 | 2.00 | |
| | completed by ALL HOSPITALS | I TOT ALL NO IV | esponses. Litte | ari uates iii | tile | |
| | Provider Organization and Operation | | | | I | |
| 1. 00 | Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in | e beginning of | instructions) | N | | 1.00 |
| | reporting period: 11 yes, enter the date of the change in | cordiiir 2. (3ee | Y/N | Date | V/I | |
| | | | 1.00 | 2. 00 | 3. 00 | |
| 2. 00 | Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in columouluntary or "I" for involuntary. | mn 3, "V" for | N | | | 2.00 |
| 3. 00 | Is the provider involved in business transactions, includicontracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provioficers, medical staff, management personnel, or members of directors through ownership, control, or family and otherelationships? (see instructions) | N | | | 3.00 | |
| | | | Y/N | Туре | Date | |
| | Financial Data and Danasta | | 1.00 | 2. 00 | 3. 00 | |
| 4. 00 | Financial Data and Reports Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av. column 3. (see instructions) If no, see instructions. | Y | A | | 4.00 | |
| 5. 00 | Are the cost report total expenses and total revenues diffictions on the filed financial statements? If yes, submit re | | N | | | 5. 00 |
| | These on the fired financial Statements. If yes, sability | Y/N 1.00 | Legal Oper. 2.00 | | | |
| 6. 00 | Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column | 2: If yes, i | s the provider | N | | 6. 00 |
| 7.00 | is the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see i | | und during the | N | | 7.00 |
| 8. 00 9. 00 | Were nursing programs and/or allied health programs approvious reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved | | · · | N N | | 8. 00 9. 00 |
| 10. 00 | program in the current cost report? If yes, see instructio Was an approved Intern and Resident GME program initiated | ns. | | N | | 10.00 |
| 11. 00 | cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than | | | N | | 11.00 |
| | Teaching Program on Worksheet A? If yes, see instructions. | | | | >/ /61 | |
| | | | | | Y/N 1.00 | |
| | Bad Debts | | | | 1.00 | |
| | Is the provider seeking reimbursement for bad debts? If ye If line 12 is yes, did the provider's bad debt collection | | | st reporting | Y N | 12. 00 13. 00 |
| 14. 00 | period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paym Bed Complement | ents waived? I | fyes, see ins | tructions. | N | 14.00 |
| 15. 00 | Did total beds available change from the prior cost report | | yes, see inst t A | | N N | 15. 00 |
| | | Y/N | Date | Y/N | Date | |
| | loos of the second of the seco | 1.00 | 2. 00 | 3. 00 | 4. 00 | |
| 16. 00 | PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see | Y | 03/14/2022 | Y | 03/14/2022 | 16. 00 |
| 17. 00 | instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date | N | | N | | 17. 00 |
| 18. 00 | in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this | N | | N | | 18. 00 |
| 19. 00 | cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions. | N | | N | | 19. 00 |
| | | | | | | |

| Heal th | Financial Systems HENRY COUNTY MEN | MORIAL HOSPITAL | - | In Lie | u of Form CM | IS-2552-10 |
|---------|--|-----------------|--------------|--|--|------------------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provi der C | CN: 15-0030 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet S Part II Date/Time F 5/26/2022 S | Prepared: |
| | | | i pti on | Y/N | Y/N | |
| 20. 22 | 161: 1/ 17: | | 0 | 1.00 | 3.00 | 00.05 |
| 20. 00 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: | | | N | N | 20.00 |
| | | Y/N | Date | Y/N | Date | |
| | - | 1.00 | 2. 00 | 3. 00 | 4. 00 | |
| 21. 00 | Was the cost report prepared only using the provider's records? If yes, see instructions. | N | | N | | 21.00 |
| | | | | | 1.00 | |
| | COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC | EPT CHILDRENS | HOSPI TALS) | | | |
| | Capital Related Cost | | | | | |
| 22. 00 | Have assets been relifed for Medicare purposes? If yes, se | | | | N | 22. 00 |
| 23. 00 | Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions. | due to apprai | sals made du | ring the cost | N | 23.00 |
| 24. 00 | Were new leases and/or amendments to existing leases enter If yes, see instructions | ed into during | this cost r | eporting period? | N | 24. 00 |
| 25. 00 | Have there been new capitalized leases entered into during linstructions. | ? If yes, see | N | 25. 00 | | |
| 26. 00 | Were assets subject to Sec. 2314 of DEFRA acquired during t linstructions. | lf yes, see | N | 26. 00 | | |
| 27. 00 | Has the provider's capitalization policy changed during th copy. | e cost reporti | ng period? I | f yes, submit | N | 27. 00 |
| 28. 00 | Unterest Expense Were new Loans, mortgage agreements or letters of credite | ntered into du | ring the cos | t reporting | Y | 28. 00 |
| 29. 00 | period? If yes, see instructions. Did the provider have a funded depreciation account and/or | | · · | . 0 | N | 29. 00 |
| 30. 00 | treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat | ructi ons | | ŕ | N | 30.00 |
| 31. 00 | instructions. Has debt been recalled before scheduled maturity without i | , | , | | l N | 31.00 |
| | instructions. Purchased Services | | | | | |
| 32. 00 | Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr | | ed through c | ontractual | N | 32.00 |
| 33. 00 | If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions. | plied pertaini | ng to compet | tive bidding? If | N | 33. 00 |
| 34. 00 | Provider-Based Physicians Are services furnished at the provider facility under an a | rrangement wit | h provider-h | ased physicians? | Y | 34.00 |
| | If yes, see instructions. If line 34 is yes, were there new agreements or amended ex | · · | · | . , | l N | 35. 00 |
| 33.00 | physicians during the cost reporting period? If yes, see i | | THE WITH THE | Y/N | Date | 33.00 |
| | | | | 1.00 | 2.00 | |
| | Home Office Costs | | | | | |
| | Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p | repared by the | home office | N N N | | 36. 00 37. 00 |
| 38. 00 | If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of | | | f N | | 38. 00 |
| 39. 00 | , · · · · · · · · · · · · · · · · · · · | | | s, N | | 39. 00 |
| 40. 00 | see instructions. 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 | | | | | |
| 41. 00 | Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, | KYLE | | SMI TH | | 41.00 |
| 42. 00 | respectively. Enter the employer/company name of the cost report | BLUE & CO., LL | .C | | | 42. 00 |
| 43. 00 | preparer. Enter the telephone number and email address of the cost | 317-713-7957 | | KCSMI TH@BLUEAN | DCO. COM | 43.00 |
| | report preparer in columns 1 and 2, respectively. | 1 | | I | | II |

| Heal th | Financial Systems HENRY COUNTY ME | EMORIAL HOSPITAL | In Lieu of Form CMS-2552-10 | | | | |
|---------|--|-----------------------|-----------------------------|--------------------------|-------|--|--|
| H0SPI | TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0030 | Peri od: From 01/01/2021 | Worksheet S-2 Part II | | | |
| | | | To 12/31/2021 | | | | |
| | | | | | | | |
| | | 3. 00 | | | | | |
| | Cost Report Preparer Contact Information | | | | | | |
| 41.00 | Enter the first name, last name and the title/position | DI RECTOR | | | 41.00 | | |
| | held by the cost report preparer in columns 1, 2, and 3, | | | | | | |
| | respectively. | | | | | | |
| 42.00 | Enter the employer/company name of the cost report | | | | 42.00 | | |
| | preparer. | | | | | | |
| 43.00 | Enter the telephone number and email address of the cost | | | | 43.00 | | |
| | report preparer in columns 1 and 2, respectively. | | | | | | |

Heal th Fi nancial SystemsHENRY COUNTHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0030

| | | | | | | To | 12/31/2021 | Date/Time Pr 5/26/2022 3: | | |
|------------------|---|-------------|----|---------|-----------|----|------------|------------------------------|-----|----------------|
| | | | | | | | | 1/P Days / | 1 | DIII |
| | | | | | | | | 0/P Visits / | | |
| | | | | | | | | Tri ps | | |
| | Component | Worksheet A | No | of Beds | Bed Days | C | CAH Hours | Title V | | |
| | | Line Number | | | Available | | | | | |
| 4 00 | The state Allie A Bala Code as 5 (7 and | 1. 00 | | 2. 00 | 3.00 | | 4. 00 | 5. 00 | + | 1 00 |
| 1. 00 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and | 30. 00 | | 38 | 13, 87 | U | 0. 00 | (| | 1. 00 |
| | Hospice days)(see instructions for col. 2 | | | | | | | | | |
| | for the portion of LDP room available beds) | | | | | | | | | |
| 2.00 | HMO and other (see instructions) | | | | | | | | | 2. 00 |
| 3. 00 | HMO IPF Subprovider | | | | | | | | | 3.00 |
| 4.00 | HMO IRF Subprovider | | | | | | | | İ | 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 | | | 38 | 13, 87 | 0 | 0. 00 | (| | 7.00 |
| | beds) (see instructions) | | | | | | | | | |
| 8. 00 | INTENSIVE CARE UNIT | 31. 00 | | 10 | 3, 65 | 0 | 0. 00 | (| | 8. 00 |
| 9.00 | CORONARY CARE UNIT | | | | | | | | | 9.00 |
| 10.00 | BURN INTENSIVE CARE UNIT | | | | | | | | | 0.00 |
| 11. 00 12. 00 | SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) | | | | | | | | | 1. 00 2. 00 |
| 13.00 | NURSERY | 43.00 | | | | | | , | | 3.00 |
| 14. 00 | Total (see instructions) | 43.00 | | 48 | 17, 52 | 0 | 0. 00 | | | 4. 00 |
| 15. 00 | CAH visits | | | 10 | 17,02 | | 0.00 | Ò | | 5. 00 |
| 16. 00 | SUBPROVIDER - IPF | | | | | | | | | 6. 00 |
| 17. 00 | SUBPROVIDER - IRF | | | | | | | | | 7.00 |
| 18.00 | SUBPROVI DER | | | | | | | | 1 | 8.00 |
| 19. 00 | SKILLED NURSING FACILITY | | | | | | | | 1 | 9. 00 |
| 20.00 | NURSING FACILITY | | | | | | | | | 0.00 |
| 21. 00 | OTHER LONG TERM CARE | | | | | | | | | 1.00 |
| 22. 00 | HOME HEALTH AGENCY | 101. 00 | | | | | | (| | 2.00 |
| 23. 00 | AMBULATORY SURGICAL CENTER (D. P.) | 444.00 | | | | | | | | 3.00 |
| 24. 00 | HOSPICE | 116.00 | | 0 | | 0 | | | | 4.00 |
| 24. 10 25. 00 | HOSPICE (non-distinct part) CMHC - CMHC | 30. 00 | | | | | | | | 4. 10 5. 00 |
| 26. 00 | RURAL HEALTH CLINIC | 88. 00 | | | | | | , | | 6. 00 |
| 26. 01 | RURAL HEALTH CLINIC II | 88. 01 | | | | | | | | 6. 01 |
| 26. 02 | RURAL HEALTH CLINIC III | 88. 02 | | | | | | | – | 6. 02 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 89. 00 | | | | | | (| | 6. 25 |
| 27. 00 | Total (sum of lines 14-26) | | | 48 | | | | | | 7.00 |
| 28.00 | Observation Bed Days | | | | | | | (|) 2 | 8. 00 |
| 29. 00 | Ambul ance Trips | | | | | | | | 2 | 9. 00 |
| 30.00 | Employee discount days (see instruction) | | | | | | | | | 0. 00 |
| 31. 00 | Employee discount days - IRF | | | | | | | | | 1.00 |
| 32.00 | Labor & delivery days (see instructions) | | | 0 | | 0 | | | | 2.00 |
| 32. 01 | Total ancillary labor & delivery room | | | | | | | | 3 | 2. 01 |
| 22 00 | outpatient days (see instructions) | | | | | | | | 1 | 3. 00 |
| 33. 00 33. 01 | LTCH non-covered days LTCH site neutral days and discharges | | | | | | | | | 3. 00 3. 01 |
| 55. 01 | Lion of to houth at days and discharges | | ı | | I | 1 | ı | l | 1 3 | J. U I |

Provi der CCN: 15-0030

Peri od: Worksheet S-3
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/26/2022 3:43 pm

| | | _ | | | | 5/26/2022 3:4 | 3 pm |
|--------|--|-------------|--------------|-----------|---------------|---------------|--------|
| | | I/P Days | / O/P Visits | / Tri ps | Full Time E | Equi val ents | |
| | | | | | | | |
| | | | | | | | |
| | Component | Title XVIII | Title XIX | Total All | Total Interns | Employees On | |
| | | | | Pati ents | & Residents | Payrol I | |
| | | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and | 2, 833 | 267 | 7, 219 | | | 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, 059 | 1, 432 | | | | 2.00 |
| 3.00 | HMO IPF Subprovider | 0 | 0 | | | | 3.00 |
| 4.00 | HMO IRF Subprovider | 0 | 0 | | | | 4.00 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | 0 | 0 | 0 | | | 5.00 |
| 6.00 | Hospital Adults & Peds. Swing Bed NF | | 0 | 0 | | | 6.00 |
| 7.00 | Total Adults and Peds. (exclude observation | 2, 833 | 267 | 7, 219 | | | 7.00 |
| | beds) (see instructions) | | | | | | |
| 8.00 | INTENSIVE CARE UNIT | 661 | 0 | 2, 030 | | | 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 | 435 | | | 13.00 |
| 14.00 | Total (see instructions) | 3, 494 | 267 | 9, 684 | 0.00 | 457. 63 | 14.00 |
| 15.00 | CAH visits | o | 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 | | | | | | 19.00 |
| 20.00 | NURSING FACILITY | | | | | | 20.00 |
| 21.00 | OTHER LONG TERM CARE | | | | | | 21.00 |
| 22.00 | HOME HEALTH AGENCY | 3, 962 | 598 | 9, 695 | 0.00 | 12. 88 | 22.00 |
| 23.00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | | 23.00 |
| 24.00 | HOSPI CE | o | 0 | 0 | 0.00 | 5. 71 | 24.00 |
| 24. 10 | HOSPICE (non-distinct part) | | | 44 | | | 24. 10 |
| 25.00 | CMHC - CMHC | | | | | | 25. 00 |
| 26.00 | RURAL HEALTH CLINIC | 5, 976 | 3, 784 | 21, 735 | 0.00 | 56. 10 | 26.00 |
| 26. 01 | RURAL HEALTH CLINIC II | 6, 976 | 16, 362 | 48, 721 | 0.00 | 91. 09 | 26. 01 |
| 26. 02 | RURAL HEALTH CLINIC III | 896 | 904 | 4, 664 | 0.00 | 6. 20 | 26. 02 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | o | o | 0 | 0.00 | 0.00 | 26. 25 |
| 27. 00 | Total (sum of lines 14-26) | | | | 0. 00 | 629. 61 | 27.00 |
| 28. 00 | Observation Bed Days | | 243 | 1, 404 | | | 28.00 |
| 29. 00 | Ambul ance Trips | o | | , | | | 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) | o | 2 | 50 | | | 32.00 |
| 32. 01 | Total ancillary labor & delivery room | | آ | 0 | | | 32. 01 |
| | outpatient days (see instructions) | | | | | | |
| 33.00 | LTCH non-covered days | o | | | | | 33.00 |
| | LTCH site neutral days and discharges | o | | | | | 33. 01 |
| -5.01 | | · ~ | | 1 | 1 | | , |

 Heal th Fi nancial
 Systems
 HENRY COUNTY MEMORIAL HOSPITAL

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CO

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

| Full Time Equivalents Nonpaid Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XVIII Title XIX Total All Patients Title V Title XVIII Title XVIII Title XVIII Patients Title V Title XVIII Title XVIII Title XVIII Patients Title V Title XVIII Title XVIII Title XVIII Patients Title XVIII Patients Title XVIII Title XVIX Total All II Total All II Title XVIX Total All II T |
|--|
| Nonpaid Nonpaid Workers Work |
| Workers 12.00 13.00 14.00 15.00 15.00 |
| 11.00 12.00 13.00 14.00 15.00 |
| 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 HM0 and other (see instructions) 3.00 HM0 IPF Subprovi der 4.00 HM0 IPF Subprovi der 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 10.00 BURN INTENSI VE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 2.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER FACILITY 19.00 SKILLED NURSING FACILITY |
| Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 |
| For the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 390 2.00 3.00 HM0 IPF Subprovider 0 0 3.00 4.00 HM0 IPF Subprovider 0 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 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 SUBRI INTENSIVE CARE UNIT 9.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 UNSERY 14.00 Total (see instructions) 0.00 0 881 45 2,437 14.00 15.00 CAH visits 15.00 CAH visits 15.00 CAH visits 15.00 SUBPROVIDER - IPF 16.00 18.00 SUBPROVIDER - IRF 17.00 SUBPROVIDER IRF 18.00 SUBPROVIDER IRF 18.00 SUBPROVIDER IRF 18.00 18.00 19.00 SKILLED NURSING FACILITY 19.00 |
| 2.00 HMO and other (see instructions) 430 390 2.00 3.00 4.00 HMO IPF Subprovider 0 4.00 4.00 HMO IRF Subprovider 0 4.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 Total (see instructions) 0.00 0 881 45 2,437 14.00 15.00 CAH visits 15.00 16.00 SUBPROVIDER - IRF 18.00 19.00 SKILLED NURSING FACILITY 19.00 19.00 SKILLED NURSING FACILITY 19.00 1 |
| 3. 00 |
| 3. 00 |
| 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 For total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 1.00 BURN INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 0.00 0 881 45 2,437 14.00 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 19.00 SKILLED NURSING FACILITY 19.00 19.00 SKILLED NURSING FACILITY 19.00 |
| 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 18.00 SUBPROVIDER 18.00 SUBPROVIDER 18.00 SUBPROVIDER 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY |
| 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY |
| 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY |
| Beds) (see instructions) |
| 8. 00 INTENSIVE CARE UNIT |
| 9. 00 CORONARY CARE UNIT 9. 00 10. 00 BURN I NTENSI VE CARE UNIT 10. 00 11. 00 SURGI CAL I NTENSI VE CARE UNIT 11. 00 12. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 13. 00 NURSERY 13. 00 Total (see i instructions) 0. 00 0 881 45 2, 437 14. 00 15. 00 CAH visits 15. 00 SUBPROVI DER - I PF 17. 00 SUBPROVI DER - I RF 17. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACILITY 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 10. 00 19. 00 |
| 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY |
| 11. 00 SURGI CAL INTENSI VE CARE UNI T 11. 00 12. 00 13. 00 14. 00 Total (see instructions) 0. 00 0 881 45 2, 437 14. 00 15. 00 CAH visits 15. 00 SUBPROVI DER - I PF 16. 00 17. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACILI TY 19. 00 19. 00 10. 00 1 |
| 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVI DER - I PF 17. 00 SUBPROVI DER 18. 00 SUBPROVI DER 19. 00 SKI LLED NURSI NG FACILITY |
| 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVI DER - I PF 17. 00 SUBPROVI DER 18. 00 SUBPROVI DER 19. 00 SKI LLED NURSI NG FACILITY 13. 00 13. 00 0 881 45 2, 437 14. 00 15. 00 15. 00 15. 00 17. 00 18. 00 19. 00 19. 00 |
| 14. 00 Total (see instructions) 0. 00 0 881 45 2, 437 14. 00 15. 00 CAH visits 15. 00 16. 00 SUBPROVI DER - I PF 16. 00 17. 00 SUBPROVI DER - I RF 17. 00 18. 00 SUBPROVI DER 18. 00 19. 00 SKILLED NURSING FACILITY 19. 00 |
| 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 18. 00 SUBPROVIDER 18. 00 SKILLED NURSING FACILITY 19. 00 |
| 16. 00 SUBPROVI DER - I PF 16. 00 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACI LI TY 19. 00 19. |
| 17. 00 SUBPROVI DER - I RF 17. 00 18. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACI LI TY 19. 00 |
| 18. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACI LI TY 19. 00 19 |
| 19.00 SKILLED NURSING FACILITY 19.00 |
| |
| 20, 00 11003110 1 ACILIT |
| 21. 00 OTHER LONG TERM CARE |
| 22. 00 HOME HEALTH AGENCY 0. 00 22. 00 |
| 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) |
| 23. 00 AWBDCATOKT SOKGLOAL CENTER (B. F.) 24. 00 HOSPI CE 0. 00 24. 00 |
| 24. 00 HOSPI CE (non-distinct part) 24. 10 |
| 25. 00 CMHC - CMHC 25. 00 |
| 26. 00 RURAL HEALTH CLINIC 0. 00 26. 00 |
| 26. 00 RURAL HEALTH CLINIC |
| |
| |
| |
| |
| 28. 00 Observation Bed Days |
| 29. 00 Ambul ance Trips 29. 00 Fmpl avec discount days (see instruction) |
| 30.00 Employee discount days (see instruction) 30.00 |
| 31.00 Employee discount days - IRF |
| 32.00 Labor & delivery days (see instructions) 32.01 Tatal analytic and the second sec |
| 32.01 Total ancillary labor & delivery room |
| outpatient days (see instructions) |
| 33. 00 LTCH non-covered days 0 33. 00 |
| 33.01 LTCH site neutral days and discharges 0 33.01 |

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0030 Peri od: Worksheet S-3 From 01/01/2021 Part II Date/Time Prepared: 12/31/2021 5/26/2022 3:43 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Reported ion of Sal ari es Related to Sal ari es (col. 2 ± col. Salaries in (from Wkst 3) col 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 PART II - WAGE DATA SALARI ES 200 00 1.00 Total salaries (see 56, 157, 285 -6,640 56, 150, 645 1, 309, 579. 00 42.88 1.00 instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3 00 O 0 00 Non-physician anesthetist Part 0 00 3 00 4.00 Physician-Part A -15,000 15,000 180.00 83.33 4.00 Administrative 4.01 Physicians - Part A - Teaching 0.00 0.00 4.01 146. 40 5.00 Physician and Non 10, 542, 872 10, 542, 872 72, 015. 00 5.00 Physician-Part B 6.00 Non-physician-Part B for 8, 816, 941 8, 816, 941 293, 715. 00 30.02 6.00 hospital-based RHC and FQHC servi ces Interns & residents (in an 21.00 7.00 0 0.00 0.00 7.00 0 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office and/or related 0 0.00 0.00 8.00 organization personnel 9 00 SNF 44.00 0.00 0 00 9 00 10.00 Excluded area salaries (see 3, 418, 159 297, 316 3, 715, 475 100, 019. 00 37.15 10.00 instructions) OTHER WAGES & RELATED COSTS 1, 234, 566 11.00 Contract labor: Direct Patient 1, 234, 566 23, 286. 00 53.02 11.00 Contract Labor: Top Level 0.00 12.00 0 0 0.00 12.00 management and other management and administrative servi ces 13.00 Contract Labor: Physician-Part 171,000 0 171, 000 1, 373. 00 124. 54 13.00 A - Administrative 14.00 Home office and/or related 0 0 0.00 14.00 0.00 organization salaries and wage-related costs 14.01 Home office salaries 0 0.00 0.00 14.01 Related organization salaries 0.00 14.02 14.02 0 0.00 15.00 Home office: Physician Part A 0 0.00 0.00 15.00 - Administrative 0 16.00 Home office and Contract 0.00 0.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A О 0.00 0.00 16.01 - Teachi ng Home office contract 16.02 16.02 0 0.00 0.00 Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see 10, 360, 808 10, 360, 808 17.00 instructions) 18.00 Wage-related costs (other) 18 00 (see instructions) 19.00 Excluded areas 1, 203, 328 1, 203, 328 19.00 20.00 Non-physician anesthetist Part 20.00 21.00 Non-physician anesthetist Part 0 0 21.00 22.00 Physician Part A -3,002 3,002 22.00 Administrative 22.01 Physician Part A - Teaching 22.01 1, 449, 311 Physician Part B 1, 449, 311 23.00 23 00 24.00 Wage-related costs (RHC/FQHC) 3, 278, 179 3, 278, 179 24.00 25.00 Interns & residents (in an 25.00 approved program) 25.50 Home office wage-related 0 C 0 25.50 (core) 25.51 Related organization 0 25.51 wage-related (core) Home office: Physician Part A 25.52 0 25.52

- Administrative wage-related (core)

| Hear th | Financiai Systems | HE | NRY COUNTY MEN | IURI AL HUSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--------------------------------|--------------|----------------|------------------|---------------|-----------------|-----------------|---------|
| HOSPI T | AL WAGE INDEX INFORMATION | | | Provi der C | CN: 15-0030 | Peri od: | Worksheet S-3 | |
| | | | | | | From 01/01/2021 | Part II | |
| | | | | | | To 12/31/2021 | | |
| | | | | | | | 5/26/2022 3: 4 | 3 pm |
| | | Wkst. A Line | Amount | Reclassi fi cat | | Pai d Hours | Average | |
| | | Number | Reported | i on of | Sal ari es | Related to | Hourly Wage | |
| | | | | Sal ari es | (col.2 ± col. | | (col. 4 ÷ | |
| | | | | (from Wkst. | 3) | col. 4 | col . 5) | |
| | | | | A-6) | | | | |
| | | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | 6. 00 | |
| 25. 53 | J | | 0 | 0 | 1 | 0 | | 25. 53 |
| | - Teaching - wage-related | | | | | | | |
| | (core) | | | | | | | |
| | OVERHEAD COSTS - DIRECT SALARI | ES | | | | | | |
| 26.00 | Employee Benefits Department | 4.00 | 1, 604, 905 | -1, 294, 173 | 310, 73 | 2 8, 990. 00 | 34. 56 | 26.00 |
| 27.00 | Administrative & General | 5. 00 | 6, 601, 487 | 149, 832 | 6, 751, 31 | 9 145, 400. 00 | 46. 43 | 27.00 |
| 28.00 | Administrative & General under | | 279, 859 | 0 | 279, 85 | 9 1, 013. 00 | 276. 27 | 28. 00 |
| | contract (see inst.) | | | | | | | |
| 29.00 | Maintenance & Repairs | 6.00 | 0 | 0 |) | 0.00 | 0.00 | 29.00 |
| 30.00 | Operation of Plant | 7. 00 | 1, 457, 285 | 34, 576 | 1, 491, 86 | 1 49, 767. 00 | 29. 98 | 30.00 |
| 31.00 | Laundry & Linen Service | 8.00 | 0 | 0 | 1 | 0.00 | 0.00 | 31.00 |
| 32.00 | Housekeepi ng | 9.00 | 0 | 0 | 1 | 0.00 | 0.00 | 32.00 |
| 33.00 | Housekeeping under contract | | 921, 605 | l o | 921, 60 | 5 61, 440. 00 | 15. 00 | 33.00 |
| | (see instructions) | | , | | | , | | |
| 34.00 | Dietary | 10.00 | 878, 075 | -528, 892 | 349, 18 | 3 15, 637. 00 | 22. 33 | 34.00 |
| 35.00 | Dietary under contract (see | | . 0 | l 0 | | 0.00 | l | 35.00 |
| | instructions) | | | | | | | |
| 36.00 | Cafeteri a | 11.00 | 0 | 292, 633 | 292, 63 | 3 13, 102. 00 | 22. 33 | 36.00 |
| 37.00 | Maintenance of Personnel | 12.00 | 0 | l o | | 0.00 | 0.00 | 37.00 |
| 38. 00 | Nursing Administration | 13. 00 | 2, 506, 693 | 85, 068 | 2, 591, 76 | | l | 1 |
| 39. 00 | Central Services and Supply | 14.00 | 570, 388 | | | · · | l | • |
| 40.00 | Pharmacy | 15. 00 | 0.0,000 | 0 |] | 0.00 | | 40.00 |
| 41. 00 | Medical Records & Medical | 16.00 | 704, 536 | 16, 716 | 721, 25 | | | 41.00 |
| 11.00 | Records Li brary | 10.00 | 704, 330 | 10,710 | 721,23 | 25,004.00 | 25. 22 | 11.00 |
| 42 00 | Social Service | 17. 00 | 0 | 1 | | 0.00 | 0.00 | 42.00 |
| | Other General Service | 18. 00 | 0 | | | 0.00 | l | 43.00 |
| 45.00 | Tottier delierar Service | 10.00 | U | 1 | 1 | 0.00 | 0.00 | 1 45.00 |

| HOSPI 7 | AL WAGE INDEX INFORMATION | | | Provi der C | | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part III Date/Time Prep 5/26/2022 3:43 | pared: |
|---------|--------------------------------|-------------|--------------|------------------|---------------|---|---|--------|
| | | Worksheet A | Amount | Recl assi fi cat | Adj usted | Pai d Hours | Average | |
| | | Line Number | Reported | ion of | Sal ari es | Related to | Hourly Wage | |
| | | | | Sal ari es | (col.2 ± col. | Salaries in | (col. 4 ÷ | |
| | | | | (from | 3) | col. 4 | col. 5) | |
| | | | | Worksheet | | | | |
| | | | | A-6) | | | | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | 6. 00 | |
| | PART III - HOSPITAL WAGE INDEX | SUMMARY | | | | | | |
| 1.00 | Net salaries (see | | 37, 998, 936 | -6, 640 | 37, 992, 29 | 6 1, 006, 302. 00 | 37. 75 | 1.00 |
| | instructions) | | | | | | | |
| 2.00 | Excluded area salaries (see | | 3, 418, 159 | 297, 316 | 3, 715, 47 | 5 100, 019. 00 | 37. 15 | 2.00 |
| | instructions) | | | | | | | |
| 3.00 | Subtotal salaries (line 1 | | 34, 580, 777 | -303, 956 | 34, 276, 82 | 1 906, 283. 00 | 37. 82 | 3.00 |
| | minus line 2) | | | | | | | |
| 4. 00 | Subtotal other wages & related | | 1, 405, 566 | 0 | 1, 405, 56 | 6 24, 659. 00 | 57. 00 | 4.00 |
| | costs (see inst.) | | | | | | | |
| 5.00 | Subtotal wage-related costs | | 10, 363, 810 | 0 | 10, 363, 81 | 0.00 | 30. 24 | 5.00 |
| | (see inst.) | | | | | | | |
| 6.00 | Total (sum of lines 3 thru 5) | | 46, 350, 153 | | | · · | | |
| 7.00 | Total overhead cost (see | | 15, 524, 833 | -1, 230, 707 | 14, 294, 12 | 5 386, 851. 00 | 36. 95 | 7.00 |
| | instructions) | | | | | | | |

| | | To 12/31/2021 | Date/Time Prep 5/26/2022 3:43 | |
|-----------------------------|------------------------|-----------------|----------------------------------|--|
| | | From 01/01/2021 | Part IV | |
| HOSPITAL WAGE RELATED COSTS | Provi der CCN: 15-0030 | Peri od: | Worksheet S-3 | |

| PART IV - WAGE RELATED COSTS 1.00 | | 10 12/31/2021 | 5/26/2022 3: 4 | |
|--|--------|---|----------------|--------|
| PART I V - WAGE RELATED COSTS | | | Amount | |
| PART I V - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Employer Contributions 2, 187, 798 1, 00 2.00 7 | | | Reported | |
| Part A - Core List | | | 1.00 | |
| RETIREMENT COST | | | | |
| 1.00 | | | | |
| 2.00 | | | | |
| 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00 0 0 0 0 0 0 0 0 0 | | | 2, 187, 798 | |
| A. 00 | 2.00 | | 0 | 2.00 |
| PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Pl an Administration fees 0 0 5.00 | 3.00 | | 0 | 3.00 |
| \$ 0.00 | 4.00 | | 0 | 4.00 |
| Column C | | | | |
| Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST 0 8.00 Heal th Insurance (Purchased or Self Funded) 0 8.00 Heal th Insurance (Self Funded without a Third Party Administrator) 0 8.01 Heal th Insurance (Self Funded with a Third Party Administrator) 9,715,691 8.02 Heal th Insurance (Purchased) 0 8.03 Heal th Insurance (Purchased) 0 9,00 Heal th Insurance (Purchased) 0 9,00 Heal th Insurance (Purchased) 0 8.03 Heal th Insurance (Purchased) 0 9,00 Heal th Insurance (Purchased) 0 126,929 10.00 Heal th Insurance (Purchased) 0 223,795 11.00 Heal th Insurance (If employee is owner or beneficiary) 0 126,929 10.00 Heal th Insurance (If employee is owner or beneficiary) 0 120,921 10.00 Heal th Insurance (If employee is owner or beneficiary) 0 120,921 10.00 Heal th Insurance (If employee is owner or beneficiary) 0 120,921 10.00 Heal th Insurance (If employee is owner or beneficiary) 0 120,921 10.00 Heal th Insurance (If employee is owner or beneficiary) 0 14.00 Heal th Insurance (If employee is owner or beneficiary) 0 14.00 Heal th Insurance (If employee is owner or beneficiary) 0 14.00 Heal th Insurance (If employee is owner or beneficiary) 0 14.00 Heal th Insurance (If employee is owner or beneficiary) 0 14.00 Heal th Insurance (If employee is owner or beneficiary) 0 14.00 Heal th Insurance (If employee is owner or beneficiary) 0 14.00 Hother Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106 0 16.00 Heal th Insurance (If employee is owner or beneficiary) 0 14.00 Heal th Insurance (If employee is owner or beneficiary) 0 14.00 Hother Heal th Care Cost (Only current year, not the extraordinar | 5.00 | | 0 | 5.00 |
| HEALTH AND INSURANCE COST | 6.00 | | 0 | 6.00 |
| Real th Insurance (Purchased or Self Funded) Real th Insurance (Self Funded without a Third Party Administrator) Real th Insurance (Self Funded without a Third Party Administrator) Real th Insurance (Self Funded with a Third Party Administrator) Real th Insurance (Self Funded with a Third Party Administrator) Real th Insurance (Self Funded with a Third Party Administrator) Real th Insurance (Self Funded with a Third Party Administrator) Real th Insurance (Purchased) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner | 7.00 | | 0 | 7.00 |
| Heal th Insurance (Self Funded without a Third Party Administrator) 8.02 Heal th Insurance (Self Funded with a Third Party Administrator) 9.715, 691 8.02 Heal th Insurance (Purchased) 9.715, 691 8.03 No | | | | |
| Heal th Insurance (Self Funded with a Third Party Administrator) 9,715,691 8.02 8.03 Heal th Insurance (Purchased) 0 8.03 9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 126,929 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 223,795 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 795,612 13.00 13.00 Disability Insurance (If employee is owner or beneficiary) 795,612 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 346,011 15.00 Non cumulative portion) 774 78 17.00 FICA-Employers Portion Only 3,619,609 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 13,340 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 07HER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions) 0 22.00 22.00 Tuition Reimbursement 32,462 23.00 23.00 Tuition Reimbursement 32,462 23.00 24.00 Part B - Other than Core Related Cost 70 70 70 70 70 70 70 7 | | | | |
| 8. 03 Heal th Insurance (Purchased) 0 0 0 0 0 0 0 0 0 | | | ı " | |
| 9. 00 Prescription Drug Plan 0 9. 00 10. 00 Dental, Hearing and Vision Plan 126, 929 10. 00 11. 00 Life Insurance (If employee is owner or beneficiary) 223, 795 11. 00 12. 00 Accident Insurance (If employee is owner or beneficiary) 0 12. 00 13. 00 Disability Insurance (If employee is owner or beneficiary) 795, 612 13. 00 14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14. 00 15. 00 'Workers' Compensation Insurance 346, 011 15. 00 16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16. 00 Non cumulative portion) 3, 619, 609 17. 00 18. 00 18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19. 00 Unemployment Insurance 13, 340 19. 00 20. 00 State or Federal Unemployment Taxes 0 0 20. 00 01 Driber Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21. | | | 9, 715, 691 | |
| 10.00 Dental, Hearing and Vision Plan 126, 929 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 223,795 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 795, 612 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 346,011 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion 16.00 17.00 FICA-Employers Portion Only 3,619,609 17.00 18.00 Unemployment Insurance 13,340 19.00 19.00 Unemployment Insurance 13,340 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 17.00 Tuit ion Reimbursement 32,462 23.00 17.01 Wage Related cost (Sum of Lines 1 -23) 7061,247 Part B - Other than Core Related Cost 10.00 10.00 10.00 10.00 10.00 10.00 10.00 | | | 0 | |
| 11.00 Life Insurance (If employee is owner or beneficiary) 223,795 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 795,612 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 346,011 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion 3,619,609 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 13,340 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 32,462 23.00 24.00 Part B - Other than Core Related Cost 3.00 | | | " | |
| 12.00 | | | | |
| 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Part B - Other than Core Related Cost | 11. 00 | | 223, 795 | |
| 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 34.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost | 12.00 | | · | |
| 15.00 'Workers' Compensation Insurance 346,011 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 3,619,609 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 13,340 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 instructions)) 22.00 Day Care Cost and Allowances 32,462 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 17,061,247 Part B - Other than Core Related Cost | 13.00 | | 795, 612 | |
| Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 11. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost | 14.00 | | 0 | 14.00 |
| Non cumulative portion) TAXES 17.00 FI CA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost | 15.00 | | 346, 011 | 15.00 |
| TAXES | 16.00 | Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. | 0 | 16.00 |
| 17.00 FICA-Employers Portion Only 3,619,609 17.00 18.00 19 | | | | |
| 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 0 DTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) 24.00 Part B - Other than Core Related Cost | | | | |
| 19.00 Unempl oyment Insurance 20.00 State or Federal Unempl oyment Taxes OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost | 17. 00 | | 3, 619, 609 | |
| 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 instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 32,462 23.00 Total Wage Related cost (Sum of Lines 1 -23) 17,061,247 Part B - Other than Core Related Cost | | | | |
| OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21. 00 22. 00 22. 00 23. 00 17, 061, 247 24. 00 | 19. 00 | Unempl oyment Insurance | 13, 340 | 19.00 |
| 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21.00 22.00 22.00 23.00 17,061,247 24.00 | 20.00 | | 0 | 20.00 |
| instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 1 instructions) 2 2.00 2 3.00 17,061,247 24.00 | | | | |
| 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 32,462 23.00 24.00 Total Wage Related cost (Sum of lines 1 -23) 17,061,247 24.00 Part B - Other than Core Related Cost 22.00 24.00 | 21.00 | | 0 | 21.00 |
| 23.00 Tuition Reimbursement 32,462 23.00 24.00 Total Wage Related cost (Sum of lines 1 -23) 17,061,247 Part B - Other than Core Related Cost 24.00 | | | | |
| 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 24.00 | | | | |
| Part B - Other than Core Related Cost | 23.00 | | | |
| | 24.00 | | 17, 061, 247 | 24.00 |
| 25.00 OTHER WAGE RELATED COSTS (SPECIFY) 25.00 | | | | |
| | 25. 00 | OTHER WAGE RELATED COSTS (SPECIFY) | | 25. 00 |

In Lieu of Form CMS-2552-10 HOSPITAL CONTRACT LABOR AND BENEFIT COST Provider CCN: 15-0030 Worksheet S-3 Peri od: From 01/01/2021 Part V 12/31/2021 Date/Time Prepared: 5/26/2022 3:43 pm Cost Center Description Contract Benefit Cost Labor 2.00 1.00 PART V - Contract Labor and Benefit Cost Hospital and Hospital-Based Component Identification: 1.00 Total facility's contract labor and benefit cost 1, 234, 566 17, 061, 247 1.00 17, 061, 247 Hospi tal 1, 234, 566 2.00 2.00 Subprovi der - IPF Subprovi der - IRF Subprovi der - (Other) 3.00 3.00 4.00 4.00 5.00 5.00 ol 0 Swi ng Beds - SNF Swi ng Beds - NF 6.00 6.00 0 Ω 0 7.00 0 7.00 8.00 Hospital -Based SNF 8.00 Hospi tal -Based NF Hospi tal -Based OLTC 9.00 9.00 10.00 10.00 Hospi tal -Based HHA 11.00 0 0 11.00

12.00

14.02

15.00 16.00

17.00

0 13.00

0 14.00

0 14.01

0 18.00

0 0

12.00

13.00

14.01

17.00 Renal Dialysis

18.00 Other

Separately Certified ASC

14.00 Hospital-Based Health Clinic RHC

14.02 Hospital - Based Health Clinic RHC 2

15. 00 Hospi tal -Based Heal th Clinic FQHC
16. 00 Hospi tal -Based-CMHC

Hospital-Based Health Clinic RHC 1

Hospi tal -Based Hospi ce

| Heal th | Financial Systems HI | ENRY COUNTY MEM | ORIAL HOSPITAL | _ | In Lie | u of Form CMS-2 | 2552-10 |
|------------------|---|--------------------|----------------|-----------------------------|--|-----------------------|------------------|
| HOME I | IEALTH AGENCY STATISTICAL DATA | | Provider C | CN: 15-0030 CCN: 15-7430 | Peri od: From 01/01/2021 To 12/31/2021 | | pared: |
| | | | | | Home Health | 5/26/2022 3: 4 PPS | . <u>3 pm</u> |
| | | | | | Agency I | | |
| 0. 00 | County | | | | 1. | 00 | 0.00 |
| 0.00 | country | Title V | Title XVIII | Title XIX | Other | Total | 0.00 |
| | HOME HEALTH AGENCY STATISTICAL DATA | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| 1.00 | Home Health Aide Hours | 0 | | 1 | 0 0 | | |
| 2. 00 | Unduplicated Census Count (see instructions) | 0.00 | 200.00 | | 0.00 ployees (Full Ti | | 2.00 |
| | | | | | | , , | |
| | | | | | | | |
| | | Enter the numb | | Staff | Contract | Total | |
| | | your norman | WOLK WEEK | | | | |
| | | | | | | | |
| | lugue ueu eu | C |) | 1. 00 | 2. 00 | 3.00 | |
| 3. 00 | HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s) | | 0.00 | 0. (| 0.00 | 0.00 | 3.00 |
| 4.00 | Director(s) and Assistant Director(s) | | | 3. 1 | 0.00 | 3. 14 | 4. 00 |
| 5. 00 6. 00 | Other Administrative Personnel Direct Nursing Service | | | 0. 7 | | | |
| 7. 00 | Nursi ng Supervi sor | | | 0.0 | 0. 00 | 0.00 | 7. 00 |
| 8. 00 9. 00 | Physical Therapy Service Physical Therapy Supervisor | | | 3. 8 | | | |
| 10.00 | Occupational Therapy Service | | | 0. 2 | 0. 00 | 0. 27 | 10.00 |
| 11. 00 12. 00 | Occupational Therapy Supervisor Speech Pathology Service | | | 0. (| | | 1 |
| 13.00 | Speech Pathology Supervisor | | | 0.0 | 0. 00 | 0.00 | 13.00 |
| 14. 00 15. 00 | Medical Social Service Medical Social Service Supervisor | | | 0. (| | | 14. 00 15. 00 |
| 16. 00 | | | | 0.8 | | | 16.00 |
| 17.00 | Home Health Aide Supervisor Other (specify) | | | 0. (| | | 17. 00 18. 00 |
| 18.00 | Tottler (specify) | | | 0.0 | 0.00 | CBSA Data | 18.00 |
| | HOME HEALTH AGENCY CBSA CODES | | | | | 1.00 | |
| 19. 00 | Enter in column 1 the number of CBSAs where | | | | | 3 | |
| 20. 00 | List those CBSA code(s) in column 1 serviced first code). | l during this co | ost reporting | period (line | 20 contains the | 17140 | 20.00 |
| 20. 01 | | | | | | 34620 | 20. 01 |
| 20. 02 | | Full Ep | oi sodes | | | 99915 | 20.02 |
| | | | With Outliers | LUPA Epi sode | | Total (cols. | |
| | | Outliers 1.00 | 2.00 | 3.00 | Epi sodes 4.00 | 1-4) 5. 00 | |
| 21. 00 | PPS ACTIVITY DATA Skilled Nursing Visits | 1, 116 | 165 | | 11 0 | 1, 292 | 21.00 |
| 22. 00 | Skilled Nursing Visit Charges | 396, 480 | 58, 672 | 3, 9 | | 459, 068 | 22. 00 |
| 23. 00 24. 00 | Physical Therapy Visits Physical Therapy Visit Charges | 1, 452 516, 147 | 208 73, 929 | 1 | 5 O | 1, 665 591, 856 | 1 |
| 25.00 | Occupational Therapy Visits | 163 | 71 | | 0 0 | 234 | 25. 00 |
| 26. 00 27. 00 | Occupational Therapy Visit Charges Speech Pathology Visits | 57, 050 87 | 24, 782 56 | 1 | 0 0 | 81, 832 143 | 1 |
| 28. 00 | Speech Pathology Visit Charges | 30, 972 | 19, 936 | 1 | 0 0 | 50, 908 | 1 |
| 29. 00 30. 00 | Medical Social Service Visits Medical Social Service Visit Charges | 0 | C | | 0 0 | 0 0 | 1 |
| 31. 00 | Home Heal th Aide Visits | 486 | 142 | l . | 0 0 | 628 | 1 |
| 32. 00 33. 00 | Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, | 81, 074 3, 304 | 23, 698 642 | 1 | 0 16 0 | 104, 772 3, 962 | 1 |
| 33.00 | 29, and 31) | 3, 304 | 042 | | 0 | 3, 702 | 33.00 |
| 34. 00 35. 00 | Other Charges Total Charges (sum of lines 22, 24, 26, 28, | 0 1, 081, 723 | 201, 017 | 5, 69 | 0 0 | 0 1 288 436 | 1 |
| 33.00 | 30, 32, and 34) | | 201, 017 | | | ,, | |
| 36. 00 | Total Number of Episodes (standard/non outlier) | 281 | | | 10 0 | 291 | 36.00 |
| | Total Number of Outlier Episodes | | 28 | 1 | 0 | | 37.00 |
| 38. 00 | Total Non-Routine Medical Supply Charges | 1, 123 | 662 | 1 | 0 0 | 1, 785 | 38.00 |

| alth Financial Systems HE USPITAL-BASED RHC/FQHC STATISTICAL DATA | INCT COUNTY WILK | MORIAL HOSPITAL Provider (| CCN: 15-0030 | Peri od: | | |
|--|---------------------------------|---------------------------------|----------------------------|----------------------------------|---------------------------------------|---------|
| | | | CCN: 15-8520 | From 01/01/2021 To 12/31/2021 | 1 1 Date/Time Pre | epare |
| | | | | RHC I | Date/Time Pro 5/26/2022 3: 4 Cost | то рііі |
| | | | | | | |
| Clinic Address and Identification | | | | 1 | . 00 | |
| 00 Street | | | | 2200 FOREST R | IDGE PARKWAY | 1. |
| | | | i ty | State | | |
| OO City Ctata 71D Cada Causty | | NEW CASTLE | . 00 | 2. 00 | | 1 |
| 00 City, State, ZIP Code, County | | NEW CASILE | | | V47362 | 2. |
| | | | | | 1. 00 | |
| 00 HOSPITAL-BASED FQHCs ONLY: Designation - Ente | er "R" for rur | al or "U" for | | | 0 | 3. |
| | | | | nt Award 1.00 | | |
| Source of Federal Funds | | | | 1.00 | 2.00 | |
| OO Community Health Center (Section 330(d), PHS | Act) | | | | | 4. |
| 00 Migrant Health Center (Section 329(d), PHS Ad | | | | | | 5 |
| 00 Health Services for the Homeless (Section 340 Appalachian Regional Commission | J(d), PHS Act) | | | | | 6 |
| 00 Look-Alikes | | | | | | 8 |
| 00 OTHER (SPECIFY) | | | | | | 9 |
| | | | | | | |
| .00 Does this facility operate as other than a ho | ocni tal bacad | DUC or FOUCA F | ntor "V" for | 1. 00 N | _ | 10 |
| yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.) | ate number of | other operation | ons in column | | | |
| | Sur | nday | N | londay | Tuesday | |
| | from | to | from | to | _ | _ |
| Facility hours of operations (1) | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5.00 | - |
| . 00 CLINIC | | | 08: 00 | 17: 00 | 08: 00 | 11 |
| | | | • | | | |
| 00 111 | | | 1. 10 | 1.00 | 2. 00 | 100 |
| .00 Have you received an approval for an exception of the second lates a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. In number shelow. | d in CMS Pub. umn 1. If yes, | 100-04, chapte enter in colu | er 9, section umn 2 the | Y N | 0 | 12 |
| | | | Prov | ider name | CCN number | |
| | | | | 1. 00 | 2. 00 | |
| .00 RHC/FQHC name, CCN number | Y/N | V | XVIII | XIX | Total Visits | 14 |
| | 1, 00 | 2.00 | 3.00 | 4. 00 | | |
| .00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and | | 2.00 | 3.00 | 4.00 | 3. 00 | 15 |
| 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and | | | | | | |
| XIX, as applicable. Enter in column 5 the number of total visits for this provider. | | | | | | |
| (see instructions) | | Co | unty | | <u> </u> | |
| (see instructions) | | | . 00 | | | |
| | | _ | | 1 | | 2 |
| | T | HENRY | | | | _ |
| | Tuesday | HENRY Wedr | nesday | | rsday to | |
| | Tuesday to 6.00 | HENRY | nesday to 8.00 | Thu from 9.00 | rsday to 10.00 | |

| Health Financial Systems H | ENRY COUNTY MEM | ORI AL HOSPI TAL | = | In Lie | u of Form CMS-2 | 2552-10 |
|--|-----------------|------------------|--------------|-----------------|-----------------|---------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | | Provi der C | CN: 15-0030 | Peri od: | Worksheet S-8 | |
| | | | | From 01/01/2021 | | |
| | | Component | CCN: 15-8520 | To 12/31/2021 | | |
| | | · | | | 5/26/2022 3:4 | 3 pm |
| | | | | RHC I | Cost | |
| | Fri | day | Sa | turday | | |
| | from | to | from | to | | |
| | 11. 00 | 12. 00 | 13. 00 | 14. 00 | | |
| Facility hours of operations (1) | _ | | | | | |
| 11. 00 CLINIC | 08: 00 | 17: 00 | | | | 11.00 |

| | Financial Systems HE | NRY COUNTY MEM | MORIAL HOSPITAL | - | In Lie | eu of Form CMS- | 2552-1 |
|----------------|---|---------------------------------|---------------------------------|------------------------------|----------------------------------|---------------------------------------|----------------|
| HOSPI T | TAL-BASED RHC/FQHC STATISTICAL DATA | | Provider C | CN: 15-0030 | Peri od: | | 8 |
| | | | Component | CCN: 15-8525 | From 01/01/2021 To 12/31/2021 | Date/Time Pre 5/26/2022 3: 4 Cost | |
| | | | | | RHC II | | 43 piii |
| | | | | | | | |
| | | | | | 1. | . 00 | |
| | Clinic Address and Identification | | | | | | _ |
| 1. 00 | Street | | 1 | | 152 WI TTENBRAK | | 1.00 |
| | | | | ty | State | | |
| 2. 00 | City, State, ZIP Code, County | | NEW CASTLE | 00 | 2.00 | | 2.00 |
| 2.00 | city, State, Zir code, county | | INCW CASTLL | | 110 | 147302 | 2.00 |
| | | | | | | 1. 00 | |
| 3. 00 | HOSPITAL-BASED FQHCs ONLY: Designation - Ent | er "R" for rur | al or "U" for | urban | | | 3.00 |
| | | | | Gra | nt Award | Date | |
| | | | | | 1. 00 | 2.00 | |
| | Source of Federal Funds | | | | | | |
| 4. 00 | Community Health Center (Section 330(d), PHS | | | | | | 4.00 |
| 5. 00 | Migrant Heal th Center (Section 329(d), PHS A | | | | | | 5.00 |
| 6. 00 7. 00 | Health Services for the Homeless (Section 34 Appalachian Regional Commission | U(d), PHS ACT) | | | | | 6. 00 7. 00 |
| 8. 00 | Look-Alikes | | | | | | 8.00 |
| 9. 00 | OTHER (SPECIFY) | | | | | | 9.00 |
| 7. 00 | TOTALL (OF ESTITI) | | | 1 | | | 7.0 |
| | | | | | 1. 00 | 2.00 | |
| 10. 00 | Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o | ate number of o | other operatio | ns in column | | C | 10.00 |
| | hours.) | Sun | iday | I M | londay | Tuesday | |
| | | from | to | from | to | | |
| | | 1. 00 | 2.00 | 3. 00 | 4. 00 | _ | |
| | Facility hours of operations (1) | | | | | | |
| 11.00 | CLINIC | | | 07: 30 | 19: 00 | 07: 30 | 11.00 |
| | | | | | 1.00 | 2.00 | |
| 12. 00 | Have you received an approval for an excepti | on to the produ | uctivity stand | ard? | 1.00 Y | 2.00 | 12.00 |
| 13. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. | d in CMS Pub. umn 1. If yes, | 100-04, chapte enter in colu | r 9, section mn 2 the | | C | 13.00 |
| | Inumpers below. | | | | | | |
| | numbers below. | | | Prov | ider name | CCN number | |
| | numbers below. | | | Prov | ider name 1.00 | | |
| 14. 00 | RHC/FQHC name, CCN number | | | | 1. 00 | 2. 00 | 14.00 |
| 14. 00 | | Y/N | V | XVIII | 1. 00 XI X | 2.00 Total Visits | 14.00 |
| | RHC/FQHC name, CCN number | Y/N 1.00 | V 2.00 | | 1. 00 | 2.00 Total Visits | |
| 14. 00 | RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by | 1. 00 | | XVIII | 1. 00 XI X | 2.00 Total Visits | |
| | RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and | 1. 00 | | XVIII | 1. 00 XI X | 2.00 Total Visits | |
| | RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. | 1. 00 | 2.00 | XVIII | 1. 00 XI X | 2.00 Total Visits | |
| 15. 00 | RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | 1.00 | 2. 00 Cou | XVIII 3.00 | 1. 00 XI X | 2.00 Total Visits | 15.00 |
| 15. 00 | RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. | 1.00 | 2.00 Cou 4. HENRY | XVIII 3.00 | 1.00 XIX 4.00 | 2.00 Total Visits 5.00 | 15.0 |
| 15. 00 | RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | 1.00 | 2.00 Cot 4. HENRY Wedn | XVIII 3.00 unty 00 esday | 1.00 XIX 4.00 | 2.00 Total Visits 5.00 | 15.00 |
| 15. 00 | RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | 1.00 Tuesday | 2.00 Cou 4. HENRY Wedn from | XVIII 3.00 unty 00 esday to | 1.00 XIX 4.00 Thui | 2.00 Total Visits 5.00 | 15.00 |
| 15. 00 | RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | 1.00 | 2.00 Cot 4. HENRY Wedn | XVIII 3.00 unty 00 esday | 1.00 XIX 4.00 | 2.00 Total Visits 5.00 | 15.0 |

| Health Financial Systems H | ENRY COUNTY MEM | ORI AL HOSPI TAL | = | In Lie | u of Form CMS-2 | 2552-10 |
|--|-----------------|------------------|--------------|-----------------|-----------------|---------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | | Provi der C | CN: 15-0030 | Peri od: | Worksheet S-8 | |
| | | | | From 01/01/2021 | | |
| | | Component | CCN: 15-8525 | To 12/31/2021 | | |
| | | | | | 5/26/2022 3:4 | 3 pm |
| | | | | RHC II | Cost | |
| | Fri | day | Sa | turday | | |
| | from | to | from | to | | |
| | 11. 00 | 12. 00 | 13. 00 | 14. 00 | | |
| Facility hours of operations (1) | | | | | | |
| 11. 00 CLINIC | 07: 30 | 17: 00 | | | | 11.00 |

| | Financial Systems HE | NRY COUNTY MEN | IORIAL HOSPITAL | | In Li€ | eu of Form CMS- | 2552-10 |
|---------|--|-----------------|--|-------------------------------|----------------------------------|---------------------------------|---------|
| HOSPI T | AL-BASED RHC/FQHC STATISTICAL DATA | | Provi der C | CN: 15-0030 | Peri od: | | 3 |
| | | | Component | CCN: 15-8556 | From 01/01/2021 To 12/31/2021 | Date/Time Pre | |
| | | | | | RHC III | 21 Date/Time Pre 5/26/2022 3: 4 | +3 piii |
| | | | | | 10 | | |
| | | | | | 1. | . 00 | |
| | Clinic Address and Identification | | | | | | |
| 1. 00 | Street | | 0: | ± | 415 E. MAIN ST | | 1.00 |
| | | | | 00 | State 2.00 | | |
| 2.00 | City, State, ZIP Code, County | | CAMBRIDGE CITY | | | | 2.00 |
| 2.00 | jorty otato, Err sous, sounty | | O 11 D D D D D D D D | | | | 2.0 |
| | | | | | | 1. 00 | |
| 3. 00 | HOSPITAL-BASED FQHCs ONLY: Designation - Ent | er "R" for run | al or "U" for | | | | 3.00 |
| | | | | | nt Award | | |
| | Source of Federal Funds | | | | 1. 00 | 2.00 | |
| 4. 00 | Community Health Center (Section 330(d), PHS | Act) | | I | | | 4.00 |
| 5. 00 | Migrant Health Center (Section 329(d), PHS A | | | | | | 5.00 |
| 6. 00 | Health Services for the Homeless (Section 34) | | | | | | 6.0 |
| 7.00 | Appalachian Regional Commission | | | | | | 7.0 |
| 8.00 | Look-Alikes | | | | | | 8.0 |
| 9. 00 | OTHER (SPECIFY) | | | | | | 9.0 |
| | | | | | 1. 00 | 2 00 | |
| 10.00 | Does this facility operate as other than a he | ospi tal -based | RHC or FQHC? E | nter "Y" for | N N | | 10.0 |
| | yes or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type of hours.) | ate number of | other operatio | ns in column | | | |
| | (10di 3.) | Sun | day | M | londay | Tuesday | |
| | | from | to | from | to | from | |
| | | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| | Facility hours of operations (1) | | I | loo oo | 40.00 | 00.00 | 144.04 |
| 11.00 | CLINIC | | | 08: 00 | 19: 00 | 08: 00 | 11.00 |
| | | | | | 1. 00 | 2 00 | |
| 12. 00 | Have you received an approval for an exception | on to the prod | uctivity stand | ard? | Y | 2.00 | 12.00 |
| 13. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. | umn 1. If yes, | enter in colu | mn 2 the | N | C | 13.00 |
| | Trainber's berow. | | | Provi | der name | CCN number | |
| | | | | | | | |
| | | | | | 1. 00 | | |
| 14. 00 | RHC/FQHC name, CCN number | | | | 1. 00 | 2. 00 | 14.00 |
| 14. 00 | RHC/FQHC name, CCN number | Y/N 1,00 | V 2 00 | XVIII | 1. 00 XI X | 2.00 Total Visits | 14.00 |
| | | Y/N 1. 00 | V 2.00 | | 1. 00 | 2.00 Total Visits | |
| | Have you provided all or substantially all | | | XVIII | 1. 00 XI X | 2.00 Total Visits | |
| | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in | | | XVIII | 1. 00 XI X | 2.00 Total Visits | |
| | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by | | | XVIII | 1. 00 XI X | 2.00 Total Visits | |
| | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and | | | XVIII | 1. 00 XI X | 2.00 Total Visits | |
| | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the | | | XVIII | 1. 00 XI X | 2.00 Total Visits | |
| | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. | | | XVIII | 1. 00 XI X | 2.00 Total Visits | |
| | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the | | 2.00 | XVIII 3.00 | 1. 00 XI X | 2.00 Total Visits | |
| | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. | | 2. 00 Cou | XVIII 3. 00 | 1. 00 XI X | 2.00 Total Visits | |
| 15. 00 | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. | | 2. 00 Cou | XVIII 3.00 | 1. 00 XI X | 2.00 Total Visits | 15.00 |
| 15. 00 | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | | 2. 00 Cou 4. HENRY | XVIII 3. 00 | 1. 00 XI X 4. 00 | 2.00 Total Visits | 15. 00 |
| 15. 00 | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | Tuesday | 2.00 Cou 4. HENRY Wedne | XVIII 3.00 Inty 00 esday to | 1.00 XIX 4.00 Thui | 2.00 Total Visits 5.00 | 15.00 |
| 2. 00 | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | 1.00 Tuesday | 2.00 Cou 4. HENRY Wedne | XVIII 3.00 inty 00 esday | 1. 00 XI X 4. 00 | 2.00 Total Visits 5.00 | 15.00 |

| Health Financial Systems | ENRY COUNTY MEM | u of Form CMS-2 | 2552-10 | | | |
|--|-----------------|-----------------|-----------------|----------------------------------|--------------------------------|-------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | | Provi der C | CN: 15-0030 | Peri od: | Worksheet S-8 | |
| | | Component | CCN: 15-8556 | From 01/01/2021 To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
| | | | | RHC III | Cost | |
| | Fri | day | Sa ⁻ | turday | | |
| | from | to | from | to | | |
| | 11. 00 | 12. 00 | 13. 00 | 14. 00 | | |
| Facility hours of operations (1) | | | | | | |
| 11. 00 CLINIC | 08: 00 | 19: 00 | 08: 00 | 12: 00 | | 11.00 |

| HOSPI 7 | Financial Systems AL-BASED HOSPICE IDENTIFICATION | DATA | | Provi der CO | CN: 15-0030 | Peri od: | u of Form CMS-2 Worksheet S-9 | |
|---------|--|-----------------|------------------|-----------------|---------------|----------------------------------|--|-----------------|
| | | | | Hospi ce CCI | | From 01/01/2021 To 12/31/2021 | PARTS I THROUG Date/Time Pre 5/26/2022 3:4 | GH IV pared: |
| | | | | | | Hospi ce I | | |
| | | Undupl i cated | | | | | | |
| | | Days | | | | | | |
| | | Title XVIII | Title XIX | Title XVIII | Title XIX | All Other | Total (sum of | |
| | | | | Skilled | Nursi ng | | col s. 1, 2 & | |
| | | | | Nursi ng | Facility | | 5) | |
| | | | | Facility | | | | |
| | | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | 6. 00 | |
| | PART I - ENROLLMENT DAYS FOR CO | JST REPORTING I | PERI ODS BEGINN | ING BEFORE OCTO | JBER 1, 2015 | | | |
| 1.00 | Hospice Continuous Home Care | | | | | | | 1.00 |
| 2.00 | Hospice Routine Home Care | | | | | | | 2.00 |
| 3.00 | Hospice Inpatient Respite Care | | | | | | | 3.00 |
| 4.00 | Hospice General Inpatient Care | | | | | | | 4.00 |
| 5. 00 | Total Hospice Days Part II - CENSUS DATA FOR COST | DEDODTI NO DED | LODG DECLAINLING | DEFORE OCTORE | 2 1 2015 | | | 5.00 |
| 6. 00 | Number of patients receiving | REPORTING PER | ODS BEGINNING | BEFORE OCTOBER | R 1, 2015 | | | 6.00 |
| 6.00 | hospice care | | | | | | | 6.00 |
| 7. 00 | Total number of unduplicated | | | | | | | 7.00 |
| 7.00 | Continuous Care hours billable | | | | | | | 7.00 |
| | to Medicare | | | | | | | |
| 8. 00 | Average Length of Stay (line 5 | | | | | | | 8.00 |
| 0.00 | / line 6) | | | | | | | 0.00 |
| 9.00 | Unduplicated census count | | | | | | | 9.00 |
| NOTE: | Parts I and II, columns 1 and 2 | also include | the days repor | ted in columns | 3 and 4. | | • | |
| | | | | Title XVIII | Title XIX | 0ther | Total (sum of | |
| | | | | | | | col s. 1 | |
| | | | | | | | through 3) | |
| | | | | 1.00 | 2. 00 | 3. 00 | 4. 00 | |
| | PART III - ENROLLMENT DAYS FOR | COST REPORTING | G PERIODS BEGI | NNING ON OR AFT | ER OCTOBER 1 | 1, 2015 | | |
| 10.00 | Hospice Continuous Home Care | | | 0 | | 0 0 | 0 | |
| 11.00 | Hospice Routine Home Care | | | 2, 543 | 1. | 25 468 | | 11.00 |
| 12.00 | Hospice Inpatient Respite Care | | | 5 | | 0 5 | | 12.00 |
| 13.00 | Hospice General Inpatient Care | | | 14 | | 3 11 | | 13.00 |
| 14.00 | Total Hospice Days | | | 2, 562 | | 28 484 | | 14.00 |
| | PART IV - CONTRACTED STATISTICA | AL DATA FOR COS | ST REPORTING P | ERIODS BEGINNIN | IG ON OR AFTE | · · | | |
| 15 00 | Hospice Inpatient Respite Care | | | 0 | | 0 | 0 | 15.00 |
| | Hospice General Inpatient Care | | | 0 | | 0 0 | | 16.00 |

| Heal th | Financial Systems | HENRY COUNTY MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 | |
|---------|---|-------------------------|---------------|----------------|------------------|--------------------------------|------------------|--|
| | SPITAL UNCOMPENSATED AND INDIGENT CARE DATA Provider CCN: 15-0030 Period: V | | | | | | | |
| | | | | | From 01/01/2021 | | | |
| | | | | | To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | pared: 3 nm | |
| | | | • | ' | | 0, 20, 2022 0 | о р | |
| | | | | | | 1. 00 | | |
| | Uncompensated and indigent care cost compo | utati on | | | | | | |
| 1. 00 | Cost to charge ratio (Worksheet C, Part I | line 202 column 3 d | ivided by li | ne 202 colum | n 8) | 0. 306255 | 1. 00 | |
| 2. 00 | Medicaid (see instructions for each line) Net revenue from Medicaid | | | | | 3, 553, 926 | 2. 00 | |
| 3. 00 | Did you receive DSH or supplemental payme | nts from Medicaid? | | | | γ | 3.00 | |
| 4. 00 | If line 3 is yes, does line 2 include all | | ntal payment | ts from Medic | ai d? | Y | 4. 00 | |
| 5.00 | If line 4 is no, then enter DSH and/or su | pplemental payments | from Medicai | d | | 0 | 5.00 | |
| 6.00 | Medicaid charges | | | | | 51, 204, 412 | 6.00 | |
| 7. 00 | Medicaid cost (line 1 times line 6) | 6 . H. P | /III | | | 15, 681, 607 | 7.00 | |
| 8. 00 | Difference between net revenue and costs < zero then enter zero) | ror medicald program | (line / mir | nus sum of II | nes 2 and 5; IT | 12, 127, 681 | 8. 00 | |
| | Children's Health Insurance Program (CHIP) |) (see instructions | for each lir | ne) | | | | |
| 9. 00 | Net revenue from stand-alone CHIP |) (555 111511 4511 5115 | 101 00011 111 | , | | 0 | 9. 00 | |
| 10.00 | Stand-alone CHIP charges | | | | | 0 | 10.00 | |
| 11. 00 | Stand-alone CHIP cost (line 1 times line | | | | | 0 | 11.00 | |
| 12. 00 | Difference between net revenue and costs | for stand-alone CHIP | (line 11 mi | nus line 9; | if < zero then | 0 | 12.00 | |
| | enter zero) Other state or local government indigent o | care program (see in | structions f | For each line | \ | | | |
| 13. 00 | Net revenue from state or local indigent | | | | | 0 | 13. 00 | |
| 14. 00 | Charges for patients covered under state | | | | | Ö | 14. 00 | |
| | 10) | | 1 13 1 | | | | | |
| 15. 00 | | | | | | | | |
| 16. 00 | | | | | | | | |
| | 13; if < zero then enter zero) Grants, donations and total unreimbursed | cost for Modicaid C | ULD and stat | o/Local indi | gont care progra | mc (coo | | |
| | instructions for each line) | cost for wedicard, c | nir anu Stat | .e/10cai iliui | gent care progra | illis (see | | |
| 17. 00 | Private grants, donations, or endowment i | ncome restricted to | fundi ng char | ity care | | 0 | 17. 00 | |
| 18.00 | Government grants, appropriations or tran | sfers for support of | hospital op | perations | | 0 | 18.00 | |
| 19. 00 | Total unreimbursed cost for Medicaid , CH | IP and state and Loc | al indigent | care program | s (sum of lines | 12, 127, 681 | 19. 00 | |
| | 8, 12 and 16) | | | Uni nsured | Insured | Total (col. 1 | | |
| | | | | patients | pati ents | + col . 2) | | |
| | | | | 1.00 | 2.00 | 3. 00 | | |
| | Uncompensated Care (see instructions for e | | | | | | | |
| 20. 00 | Charity care charges and uninsured discou | nts for the entire f | acility | 2, 445, 32 | 476, 554 | 2, 921, 875 | 20. 00 | |
| 21. 00 | (see instructions) Cost of patients approved for charity car | o and unincured disc | ounts (soo | 748, 89 | 476, 554 | 1, 225, 446 | 21 00 | |
| 21.00 | instructions) | e and unimsured drsc | ounts (see | 740, 0 | 470, 334 | 1, 225, 440 | 21.00 | |
| 22. 00 | Payments received from patients for amoun | ts previously writte | n off as | | 0 0 | 0 | 22. 00 | |
| | charity care | | | | | | | |
| 23. 00 | Cost of charity care (line 21 minus line | 22) | | 748, 89 | 2 476, 554 | 1, 225, 446 | 23. 00 | |
| | | | | | | 1 00 | | |
| 24 00 | Does the amount on line 20 column 2, incl | ude charges for nati | ent days hey | ond a Length | of stay limit | 1. 00 N | 24. 00 | |
| 24.00 | imposed on patients covered by Medicaid o | | | Jona a Tength | or stay rriiir t | IV | 24.00 | |
| 25. 00 | .00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of | | | | | | | |
| 26. 00 | stay limit Stay limit Sta | | | | | | | |
| 27.00 | | | | | | | | |
| 27. 01 | Medicare allowable bad debts for the enti | · | | | | 230, 348 | 27. 00 27. 01 | |
| 28. 00 | Non-Medicare bad debt expense (see instru | | • | • | | 5, 290, 645 | | |
| 29. 00 | Cost of non-Medicare and non-reimbursable | | xpense (see | instructions |) | 1, 700, 907 | 29.00 | |
| 30.00 | Cost of uncompensated care (line 23 colum | | 1: 20) | | | 2, 926, 353 | | |
| 31.00 | Total unreimbursed and uncompensated care | cost (Tine 19 plus | iine 30) | | | 15, 054, 034 | 31.00 | |

| Heal th | Financial Systems HE | NRY COUNTY MEMO | RIAL HOSPITAL | _ | In Lie | u of Form CMS-: | 2552-10 |
|--|---|-----------------------------------|------------------------------|---------------|---------------------------------|------------------------------|---------------------|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF | | OF EXPENSES Provider CCN: 15-0030 | | | Peri od: | Worksheet A | |
| | | | | | From 01/01/2021 o 12/31/2021 | Date/Time Pre | nared. |
| | | | | | 127 0 17 202 1 | 5/26/2022 3: 4 | 3 pm |
| | Cost Center Description | Sal ari es | 0ther | | Recl assi fi cat | Reclassi fied | |
| | | | | + col . 2) | i ons (See | Trial Balance | |
| | | | | | A-6) | (col. 3 +- col. 4) | |
| | | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1. 00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | | 5, 392, 553 | 5, 392, 553 | | 5, 303, 659 | |
| 2.00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | 4 (04 005 | 0 | (| 000, 101 | 360, 404 | |
| 4. 00 5. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL | 1, 604, 905 6, 601, 487 | 10, 803, 040 13, 260, 181 | | | 14, 732, 887 20, 007, 674 | 4. 00 5. 00 |
| 7. 00 | 00700 OPERATION OF PLANT | 1, 457, 285 | 1, 860, 736 | | | 3, 352, 597 | |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | 0 | 464, 136 | | | 464, 136 | 1 |
| 9. 00 | 00900 HOUSEKEEPI NG | 0 | 982, 548 | 1 | | 982, 548 | |
| 10.00 | 01000 DI ETARY | 878, 075 | 540, 086 | 1 | | 558, 981 | 1 |
| 11.00 | 01100 CAFETERI A | 0 | 0 | 0 074 056 | 1 .00, .0. | 468, 454 | 1 |
| 13. 00 14. 00 | 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY | 2, 506, 693 570, 388 | 365, 159 492, 454 | | | 2, 948, 972 1, 076, 375 | |
| 15. 00 | 01500 PHARMACY | 370, 388 | 5, 732, 059 | | | 5, 525, 287 | |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY | 704, 536 | 177, 085 | | | 898, 217 | 1 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | , | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 6, 696, 335 | 3, 081, 817 | | | 8, 993, 190 | |
| | 03100 INTENSIVE CARE UNIT | 1, 842, 178 | 839, 285 | 1 | | | 1 |
| 43. 00 | 04300 NURSERY ANCILLARY SERVICE COST CENTERS | 0 | 0 | 1 | 686, 829 | 686, 829 | 43.00 |
| 50. 00 | 05000 OPERATING ROOM | 5, 682, 821 | 12, 334, 748 | 18, 017, 569 | -10, 420, 668 | 7, 596, 901 | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | 1 | | 216, 311 | 1 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 2, 046, 717 | 1, 032, 392 | 3, 079, 109 | -273, 601 | 2, 805, 508 | |
| 57. 00 | 05700 CT SCAN | 208, 880 | 1, 059, 696 | | | 1, 273, 532 | • |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 149, 708 | 485, 296 | 635, 004 | 3, 552 | 638, 556 | |
| 59. 00 60. 00 | 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY | 2, 160, 567 | 3, 669, 256 | 5, 829, 823 | 51, 262 | 0 5, 881, 085 | |
| 60. 01 | 06001 BLOOD LABORATORY | 2, 100, 307 | 0,007,230 | 3,027,020 | 0 | 0,001,000 | • |
| 65.00 | 06500 RESPIRATORY THERAPY | 880, 808 | 521, 832 | 1, 402, 640 | 19, 427 | 1, 422, 067 | 1 |
| 66.00 | 06600 PHYSI CAL THERAPY | 1, 338, 157 | 904, 692 | 2, 242, 849 | 31, 578 | 2, 274, 427 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 227, 396 | 17, 040 | | | 249, 831 | |
| 68. 00 | 06800 SPEECH PATHOLOGY | 85, 396 | 6, 095 | | | 93, 517 | |
| 69. 00 71. 00 | 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 204, 992 | 203, 717 -407, 547 | | | 413, 573 1, 401, 099 | |
| 71.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | -407, 347 | -407, 547 | | 8, 351, 239 | 1 |
| | 07300 DRUGS CHARGED TO PATIENTS | o | 0 | d | 0 | 0 | 1 |
| 76.00 | 03950 CARDI AC REHAB | 168, 396 | 20, 461 | 188, 857 | 3, 995 | 192, 852 | 76.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 | 08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II | 4, 753, 808 8, 261, 189 | 2, 359, 485 | | | 5, 923, 796 | |
| 88. 01 88. 02 | 08802 RURAL HEALTH CLINIC III | 791, 652 | 4, 411, 648 508, 209 | | | 11, 406, 566 1, 199, 473 | |
| 91. 00 | 09100 EMERGENCY | 2, 916, 757 | 2, 212, 566 | | | 5, 198, 527 | 1 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101. 00 | 10100 HOME HEALTH AGENCY | 1, 145, 801 | 348, 851 | 1, 494, 652 | 14, 445 | 1, 509, 097 | 101.00 |
| 112 00 | SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE | | 0 | | vl ol | 0 | 112 00 |
| | 11400 UTI LI ZATI ON REVI EW-SNF | 0 | 0 | | | | 113. 00 114. 00 |
| | 11600 HOSPI CE | 516, 259 | 215, 006 | 731, 265 | 6, 527 | 737, 792 | |
| 118.00 | l l | 54, 401, 186 | 73, 894, 582 | | | | |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | C | 0 | | 190.00 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 1, 587, 868 | 606, 614 | 2, 194, 482 | -77, 939 | 2, 116, 543 | |
| | 07950 HOSPI TALI ST 07951 RENTAL | | 0 | | 88, 894 | | 194. 00 194. 01 |
| | 07955 OTHER NONREI MBURSABLE COSTS | | 206, 593 | 206, 593 | | 206, 593 | |
| | 07956 DR AFZAL | o | 7, 203 | 1 | | | 194.06 |
| 194. 07 | 07957 PHI LLI PS HALL | O | 0 | C | | 0 | 194. 07 |
| | 07958 OB DRS | 0 | 0 | 0 | 0 | | 194. 08 |
| | 07959 THE WATERS | 0 | 0 | | 411, 560 | 411, 560 | |
| | 07960 CAMBRI DGE CITY 07961 WELL BEING | 0 | 0 469 | 469 | 1 | | 194. 10 194. 11 |
| | 07962 ACTIVATE HEALTH EMPLOYER CLINIC | | 65, 512 | 1 | | | 194. 11 |
| | 07963 NEW CASTLE PEDIATRICS | | 0 | 05, 512 | | | 194. 13 |
| 194. 14 | 07964 HENRY COUNTY RADIOLOGY | 168, 231 | 1, 714, 014 | 1, 882, 245 | 2, 123 | 1, 884, 368 | 194. 14 |
| | 07965 HENRY COUNTY ANESTHESI OLOGY | 0 | 0 | (| 0 | | 194. 15 |
| | 07966 NEW CASTLE IMMEDICATE CARE & FAMILY | 0 | 74 404 007 | 122 452 273 | 0 | | 194. 16 |
| 200. 00 | TOTAL (SUM OF LINES 118 through 199) | 56, 157, 285 | 76, 494, 987 | 132, 652, 272 | 2 0 | 132, 652, 272 | ∠00.00 |
| | | | | | | | |

Provi der CCN: 15-0030

Period: Worksheet A From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 3:43 pm

| | | | 5/26/202 | 22 3: 43 pm |
|---|-------------------|---------------|--|------------------|
| Cost Center Description | Adjustments | Net Expenses | 0, 20, 20, | |
| · | (See A-8) | For | | |
| | | Allocation | | |
| | 6. 00 | 7. 00 | | |
| GENERAL SERVICE COST CENTERS | | | | |
| 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT | -119, 829 | | i de la companya de l | 1.00 |
| 2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP | 0 | 360, 404 | | 2. 00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | 2, 929, 332 | 17, 662, 219 | | 4. 00 |
| 5. 00 00500 ADMI NI STRATI VE & GENERAL | -4, 669, 055 | 15, 338, 619 | • | 5. 00 |
| 7. 00 00700 OPERATION OF PLANT | 0 | 3, 352, 597 | • | 7.00 |
| 8. 00 00800 LAUNDRY & LINEN SERVICE | 0 | 464, 136 | • | 8.00 |
| 9. 00 00900 HOUSEKEEPI NG | 600 | 983, 148 | • | 9.00 |
| 10. 00 01000 DI ETARY | -28, 434 | 530, 547 | | 10.00 |
| 11. 00 01100 CAFETERI A | -259, 708 | 208, 746 | • | 11.00 |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON | 89, 382 | 3, 038, 354 | • | 13.00 |
| 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY | 705 244 | 1, 076, 375 | • | 14. 00 15. 00 |
| | -795, 344 | 4, 729, 943 | | 16.00 |
| 16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS | -26, 580 | 871, 637 | | 16.00 |
| 30. 00 03000 ADULTS & PEDIATRICS | -2, 307, 523 | 6, 685, 667 | | 30.00 |
| 31. 00 03100 NTENSI VE CARE UNIT | -2, 307, 523 0 | 2, 725, 171 | l e e e e e e e e e e e e e e e e e e e | 31.00 |
| 43. 00 04300 NURSERY | 0 | 686, 829 | 1 | 43.00 |
| ANCI LLARY SERVI CE COST CENTERS | <u> </u> | 000, 027 | | 45.00 |
| 50. 00 05000 OPERATING ROOM | -3, 324, 261 | 4, 272, 640 | | 50.00 |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM | 0, 02 1, 201 | 216, 311 | • | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | -1, 286 | 2, 804, 222 | • | 54.00 |
| 57. 00 05700 CT SCAN | -720, 249 | 553, 283 | • | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | -285, 167 | 353, 389 | • | 58.00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | • | 59.00 |
| 60. 00 06000 LABORATORY | -30, 740 | 5, 850, 345 | | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0 | 0 | | 60. 01 |
| 65. 00 06500 RESPI RATORY THERAPY | 24, 020 | 1, 446, 087 | 1 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | -660, 794 | 1, 613, 633 | | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 249, 831 | | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 93, 517 | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 413, 573 | | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 1, 401, 099 | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 8, 351, 239 | | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | l control of the cont | 73. 00 |
| 76. 00 03950 CARDI AC REHAB | 0 | 192, 852 | | 76. 00 |
| OUTPATIENT SERVICE COST CENTERS | | | | |
| 88. 00 08800 RURAL HEALTH CLINIC | -440, 147 | 5, 483, 649 | • | 88.00 |
| 88. 01 08801 RURAL HEALTH CLINIC II | -2, 208, 417 | 9, 198, 149 | | 88. 01 |
| 88. 02 08802 RURAL HEALTH CLINIC III | -142, 322 | | l e e e e e e e e e e e e e e e e e e e | 88. 02 |
| 91. 00 09100 EMERGENCY | -34, 822 | 5, 163, 705 | | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY | -15, 343 | 1, 493, 754 | | 101, 00 |
| SPECIAL PURPOSE COST CENTERS | - 10, 343 | 1, 493, 734 | • | 101.00 |
| 113. 00 11300 I NTEREST EXPENSE | 0 | 0 | | 113. 00 |
| 114. 00 11400 UTI LI ZATI ON REVI EW-SNF | 0 | | • | 114.00 |
| 116. 00 11600 HOSPI CE | -15, 693 | | | 116.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | -13, 042, 380 | · | i de la companya de l | 118.00 |
| NONREI MBURSABLE COST CENTERS | | , -==, | I | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | | 190. 00 |
| 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES | -46, 133 | 2, 070, 410 | | 192.00 |
| 194. 00 07950 HOSPI TALI ST | 0 | 0 | | 194.00 |
| 194. 01 07951 RENTAL | 0 | 88, 894 | | 194. 01 |
| 194. 05 07955 OTHER NONREI MBURSABLE COSTS | 0 | 206, 593 | | 194. 05 |
| 194. 06 07956 DR AFZAL | 0 | 7, 203 | | 194. 06 |
| 194. 07 07957 PHI LLI PS HALL | 0 | 0 | | 194. 07 |
| 194. 08 07958 OB DRS | 0 | 0 | | 194. 08 |
| 194.09 07959 THE WATERS | 0 | 411, 560 | | 194. 09 |
| 194. 10 07960 CAMBRI DGE CITY | 0 | 0 | | 194. 10 |
| 194. 11 07961 WELL BEING | 0 | 469 | | 194. 11 |
| 194.12 07962 ACTIVATE HEALTH EMPLOYER CLINIC | 0 | 65, 512 | | 194. 12 |
| 194. 13 07963 NEW CASTLE PEDIATRICS | 0 | 0 | | 194. 13 |
| 194. 14 07964 HENRY COUNTY RADI OLOGY | 0 | 1, 884, 368 | | 194. 14 |
| 194. 15 07965 HENRY COUNTY ANESTHESI OLOGY | 0 | 0 |) | 194. 15 |
| 194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY | 0 | 0 | | 194. 16 |
| 200.00 TOTAL (SUM OF LINES 118 through 199) | -13, 088, 513 | 119, 563, 759 | ' | 200.00 |
| | | | | |

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Provi der CCN: 15-0030

| COST_CONTER** Time | | | | | | 1 | o 12/31/202 | 1 Date/lime Prepared: 5/26/2022 3:43 pm |
|--|--------|-----------------------------|----------------------|--------------|--------------|----------|-------------|---|
| 2.00 3.00 4.90 5.00 | | | | | | <u> </u> | | 1 |
| 1. | | | | | | | | |
| 1.00 MINESERY | | | 3. 00 | 4. 00 | 5. 00 | | | |
| 200 DEL VERY ROOM & LASOR ROOM 52.00 197.259 24.609 1 1 1 1 1 1 1 1 1 | 1 00 | | 43 00 | 504 583 | 79 130 | | | 1.00 |
| O | | 1 | | | · · | | | 2. 00 |
| April 1987 April 1988 Apr | | 0 | = | | | | | |
| 1.00 | | B - CAFETERIA | <u>.</u> | | | | | |
| 1. 00 HTM MATERS 194. 09 251, 134 154, 467 0 144, 67 0 154, 467 0 | 1. 00 | CAFETERI A | 11. 00 | | | | | 1.00 |
| The waters | | 0 | | 285, 851 | 175, 821 | | | |
| 0 | 1 00 | | 104 00 | 251 124 | 154 4/7 | | | 1.00 |
| D | 1.00 | THE WATERS | 194.09 | | | | | 1.00 |
| ENTIAL 194.01 0 88.894 | | D _ DEDDECLATION DOB | | 251, 134 | 154, 467 | | | |
| 0 | 1 00 | | 194 01 | O | 88 894 | | | 1.00 |
| 1.00 | 1.00 | 0 | 1711.01 | | | | | 1.00 |
| FOUL P | | E - EQUI PMENT RENTAL | | -1 | 22/21. | | | |
| 2.00 | 1. 00 | NEW CAP REL COSTS-MVBLE | 2.00 | 0 | 360, 404 | | | 1.00 |
| 3.00 | | EQUI P | | | | | | |
| 4.00 | | | • | - | | | | 2.00 |
| 5.00 | | | • | 0 | - | | | 3.00 |
| 0.00 | | | • | 0 | | | | 4.00 |
| 1.00 | | | | 0 | - | | | 5. 00 6. 00 |
| O 360, 404 | | | • | 0 | 0 | | | 7.00 |
| 1. DI IMPLANTABLE DEVICES | 7.00 | | | | 360_404 | | | 7:00 |
| IMPL. DEV. CHARGED TO | | F - IMPLANTABLE DEVICES | | <u> </u> | 0007 101 | | | |
| O | 1. 00 | | 72.00 | 0 | 8, 351, 239 | | | 1.00 |
| C | | PATI ENT | | | | | | |
| 1.00 EMPLOYEE BENEFITS DEPARTMENT | | 0 | | 0 | 8, 351, 239 | | | |
| 2 00 ADMINISTRATIVE & GENERAL 3 00 OPERATION OF PLANT 7 00 34, 576 0 10 IETARY 10 00 8, 093 0 10 OPERATON OF PLANT 11 00 6, 782 0 6 00 NURSI NG ADMINISTRATION 13 00 60, 006 0 11 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | | | |
| 3.00 OPERATION OF PLANT | | 1 | | | | | | 1.00 |
| 1.00 | | 1 | | | | | | 2.00 |
| 5.00 CAFETERIA | | | | | | | | 3. 00 4. 00 |
| 6. 00 NURSING ADMINISTRATION 13. 00 60. 068 0 7. 00 CENTRAL SERVICES & SUPPLY 14. 00 13. 533 0 8. 00 MEDICAL RECORDS & LIBRARY 16. 00 16. 716 0 9. 00 ADULTS & PEDIATRICS 30. 00 140. 330 0 110. 00 INTENSIVE CARE UNIT 31. 00 43. 708 0 111. 00 NURSERY 43. 00 14. 107 0 112. 00 OPERATING ROOM 50. 00 134. 833 0 123. 00 DELIVERY ROOM & LABOR ROOM 52. 00 4. 443 0 13. 00 DELIVERY ROOM & LABOR ROOM 52. 00 4. 443 0 15. 00 CT SCAN 57. 00 4. 956 0 15. 00 CT SCAN 57. 00 4. 956 0 17. 00 LABORATORY 65. 00 51. 262 0 18. 00 RESPIRATORY THERAPY 65. 00 51. 262 0 19. 00 PHYSICAL THERAPY 66. 00 31. 750 0 19. 00 PHYSICAL THERAPY 67. 00 5. 395 0 19. 00 PHYSICAL THERAPY 67. 00 5. 395 0 19. 00 SPECCH PATHOLOGY 68. 00 2. 026 0 22. 00 ELECTROCARDIOLOGY 68. 00 2. 026 0 22. 00 ELECTROCARDIOLOGY 69. 00 4. 864 0 22. 00 CARDIAT HERAPH 10. 00 4. 864 0 22. 00 CARDIAT HERAPH 10. 00 5. 395 0 23. 00 CARDIAT HERAPH 10. 00 5. 395 0 24. 00 RURAL HEALTH CLINIC II 88. 01 201. 441 0 25. 00 RURAL HEALTH CLINIC II 88. 01 201. 441 0 26. 00 RURAL HEALTH CLINIC II 88. 01 201. 441 0 27. 00 EMERGENCY 91. 00 69. 204 0 28. 00 HONSHICE HEALTH CLINIC II 88. 01 201. 441 0 29. 00 HONSHICE HEALTH CLINIC II 88. 01 201. 441 0 20. 00 COURTH DALA THERAPY 10. 00 9. 27. 186 0 20. 00 COURTH DALA THERAPY 10. 00 9. 30. 90 0 20. 00 COURTH SALITH CLINIC II 88. 01 201. 441 0 20. 00 COURTH SALITH CLINIC II 88. 01 201. 441 0 20. 00 COURTH SALITH CLINIC III 88. 01 201. 441 0 20. 00 COURTH CARDIAGN 10. 00 9. 5. 959 0 20. 00 HONSHICE SALITH CLINIC III 88. 01 201. 441 0 20. 00 COURTH SALITH CLINIC III 88. 01 201. 441 0 20. 00 COURTH SALITH CLINIC III 88. 01 201. 441 0 20. 00 COURTH SALITH CLINIC III 88. 01 201. 441 0 20. 00 COURTH SALITH CLINIC III 88. 01 201. 441 0 20. 00 COURTH SALITH CLINIC III 88. 01 201. 441 0 20. 00 COURTH SALITH CLINIC III 88. 01 201. 441 0 20. 00 COURTH SALITH CLINIC III 88. 01 201. 441 0 20. 00 COURTH SALITH CLINIC III 88. 01 201. 441 0 20. 00 COURTH SALITH CLINIC III 88. 01 201. 441 0 20. 00 COURTH SALITH CLINIC III 88. 01 201. 441 0 20. 00 COURTH SALITH CLIN | | | • | | - | | | 5. 00 |
| 7. 00 CENTRAL SERVICES & SUPPLY 14. 00 13. 533 0 MEDICAL RECORDS & LIBRARY 16. 00 16. 716 0 0 0 0 0 0 0 0 0 | | 1 | | | | | | 6.00 |
| MEDICAL RECORDS & LIBRARY 16.00 16.716 0 0 0 0 0 0 0 0 0 | | | | | | | | 7. 00 |
| 10. 00 INTENSIVE CARE UNIT 31. 00 43, 708 0 11 10 11 10 11 10 11 10 11 10 11 10 11 10 11 10 11 11 10 11 | 8. 00 | | | | | | | 8.00 |
| 11.00 | 9. 00 | ADULTS & PEDIATRICS | 30. 00 | 140, 330 | 0 | | | 9.00 |
| 12. 00 OPERATING ROOM S0. 00 134, 833 0 13. 00 DELIVERY ROOM & LABOR ROOM 52. 00 4, 443 0 13. 14. 00 RADIOLOGY-DIAGNOSTIC 54. 00 48, 561 0 17. 15. 00 CT SCAN 57. 00 4, 956 0 18. 15. 00 CT SCAN 57. 00 4, 956 0 18. 15. 00 CT SCAN 57. 00 4, 956 0 18. 15. 00 (MRI) | | 1 | | | | | | 10.00 |
| 13.00 DELIVERY ROOM & LABOR ROOM 52.00 4,442 0 1.1 1 | | 1 | | | | | | 11.00 |
| 14. 00 | | 1 | | | | | | 12.00 |
| 15. 00 | | | • | | - | | | 13. 00 14. 00 |
| 16.00 MAGNETIC RESONANCE I MAGING 58.00 3,552 0 16 (MRI) 17.00 LABDRATORY 60.00 51,262 0 17 18.00 RESPIRATORY THERAPY 65.00 20,898 0 18 19.00 PHYSI CAL THERAPY 66.00 31,750 0 19 19 19 19 19 19 19 | | | | | | | | 15.00 |
| CMRI LABORATORY | | 1 | | | - | | | 16.00 |
| 17. 00 ABORATORY 60. 00 51, 262 0 11 18 18 19 19 19 19 19 | 10.00 | | 30.00 | 3, 332 | | | | 10.00 |
| 19. 00 PHYSICAL THERAPY 66. 00 31, 750 0 20. 00 OCCUPATIONAL THERAPY 67. 00 5, 395 0 21. 00 SPECCH PATHOLOGY 68. 00 2, 026 0 22. 00 ELECTROCARDIOLOGY 69. 00 4, 864 0 23. 00 CARDI AC REHAB 76. 00 3, 995 0 24. 00 RURAL HEALTH CLINIC 88. 00 107, 712 0 25. 00 RURAL HEALTH CLINIC II 88. 01 201, 441 0 26. 00 RURAL HEALTH CLINIC III 88. 02 18, 783 0 27. 00 EMERGENCY 91. 00 69, 204 0 28. 00 HOME HEALTH AGENCY 101. 00 27, 186 0 29. 00 HOME HEALTH AGENCY 101. 00 12, 249 0 30. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 36, 727 0 31. 00 THE WATERS 194. 09 5, 959 0 32. 00 HENRY COUNTY RADIOLOGY 194. 14 3, 992 0 1 - MEDICAL DIRECTOR RECLASS 1. 00 DIRECTOR RECLASS 1. 00 MEDICAL SUPPLIES RECLASS | 17. 00 | | 60.00 | 51, 262 | 0 | | | 17. 00 |
| 20. 00 OCCUPATI ONAL THERAPY 67. 00 5, 395 0 21 21. 00 SPEECH PATHOLOGY 68. 00 2, 026 0 22 22. 00 ELECTROCARDI OLOGY 69. 00 4, 864 0 22 23. 00 CARDI AC REHAB 76. 00 3, 995 0 22 24. 00 RURAL HEALTH CLINIC 88. 00 107, 712 0 22 25. 00 RURAL HEALTH CLINIC 11 88. 01 201, 441 0 22 26. 00 RURAL HEALTH CLINIC 11 88. 02 18, 783 0 22 27. 00 EMERGENCY 91. 00 69, 204 0 22 28. 00 HOME HEALTH AGENCY 101. 00 27, 186 0 28 29. 00 HOSPI CE 116. 00 12, 249 0 22 30. 00 PHYSI CIANS' PRI VATE OFFI CES 192. 00 36, 727 0 33 31. 00 THE WATERS 194. 09 5, 959 0 33 32. 00 HENRY COUNTY RADI OLOGY 194. 14 3, 992 0 70TALS 1, 301, 529 0 | 18. 00 | RESPI RATORY THERAPY | | 20, 898 | 0 | | | 18.00 |
| 21.00 SPECH PATHOLOGY 68.00 2,026 0 22.00 ELECTROCARDI OLOGY 69.00 4,864 0 0 23.00 CARDI AC REHAB 76.00 3,995 0 22.00 ELECTROCARDI OLOGY 69.00 4,864 0 0 22.00 CARDI AC REHAB 76.00 3,995 0 22.00 CARDI AC REHAB 76.00 3,995 0 22.00 CARDI AC REHAB 76.00 3.00 107,712 0 22.00 CARDI AC REHAB 76.00 20.00 CARDI AC REHAB 76.00 CARDI AC REHABB | 19. 00 | PHYSI CAL THERAPY | 66. 00 | 31, 750 | 0 | | | 19.00 |
| 22. 00 ELECTROCARDI OLOGY 69. 00 4, 864 0 22 33. 00 CARDI AC REHAB 76. 00 3, 995 0 22 42. 00 RURAL HEALTH CLINIC 88. 00 107, 712 0 22 55. 00 RURAL HEALTH CLINIC 11 88. 01 201, 441 0 22 56. 00 RURAL HEALTH CLINIC 11 88. 02 18, 783 0 26 77. 00 EMERGENCY 91. 00 69, 204 0 22 82. 00 HOME HEALTH AGENCY 101. 00 27, 186 0 22 82. 00 HOSPI CE 116. 00 12, 249 0 22 830. 00 PHYSI CIANS' PRI VATE OFFI CES 192. 00 36, 727 0 33 831. 00 THE WATERS 194. 09 5, 959 0 33 832. 00 HENRY COUNTY RADI OLOGY 194. 14 3, 992 0 0 0 0 0 833. 00 I - MEDI CAL DI RECTOR RECLASS 1, 301, 529 0 0 0 0 0 834. 00 D - VERO RECLASS 1, 301, 529 0 0 0 0 0 0 0 0 0 | | | | | | | | 20.00 |
| 23. 00 CARDI AC REHAB 76. 00 3, 995 0 224. 00 RURAL HEALTH CLINIC 88. 00 107, 712 0 225. 00 RURAL HEALTH CLINIC III 88. 01 201, 441 0 226. 00 RURAL HEALTH CLINIC III 88. 01 201, 441 0 226. 00 RURAL HEALTH CLINIC III 88. 02 18, 783 0 227. 00 EMERGENCY 91. 00 69, 204 0 228. 00 HOME HEALTH AGENCY 101. 00 27, 186 0 229. 00 HOSPI CE 116. 00 12, 249 0 229. 00 HOSPI CE 116. 00 12, 249 0 229. 00 HOSPI CE 116. 00 12, 249 0 331. 00 THE WATERS 194. 09 5, 959 0 331. 00 THE WATERS 194. 09 5, 959 0 332. 00 HENRY COUNTY RADI OLOGY 194. 14 3, 992 0 36. 727 0 37. 30. 00 HOSPI CE 116. 00 12, 249 0 0 36. 727 0 0 37. 30. 00 HOSPI CE 116. 00 12, 249 0 0 36. 727 0 0 37. 30. 00 HOSPI CE 116. 00 12, 249 0 0 36. 727 0 0 37. 30. 00 HOSPI CE 116. 00 12, 249 0 0 36. 727 0 0 37. 30. 00 HOSPI CE 116. 00 12, 249 0 0 36. 727 0 0 37. 30. 00 HOSPI CE 116. 00 12, 249 0 0 37. 30. 00 HOSPI CE 116. 00 12, 249 0 0 37. 30. 30. 00 HOSPI CE 116. 00 12, 249 0 0 37. 30. 30. 00 HOSPI CE 116. 00 12, 249 0 0 36. 727 0 0 37. 30. 30. 30. 30. 30. 30. 30. 30. 30. 30 | | | | | - | | | 21.00 |
| 24. 00 RURAL HEALTH CLINIC | | | • | | | | | 22.00 |
| 25. 00 RURAL HEALTH CLINIC II 88. 01 201, 441 0 226. 00 RURAL HEALTH CLINIC II 88. 02 18, 783 0 227. 00 EMERGENCY 91. 00 69, 204 0 228. 00 HOME HEALTH AGENCY 101. 00 27, 186 0 229. 00 HOSPI CE 116. 00 12, 249 0 229. 00 HOSPI CE 116. 00 12, 249 0 230. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 36, 727 0 331. 00 THE WATERS 194. 09 5, 959 0 331. 00 HENRY COUNTY RADI OLOGY 194. 14 3, 992 0 TOTALS 1, 301, 529 0 1 | | | | | | | | 23. 00 24. 00 |
| 26. 00 RURAL HEALTH CLINIC III 88. 02 18, 783 0 27. 00 EMERGENCY 91. 00 69, 204 0 28. 00 HOME HEALTH AGENCY 101. 00 27, 186 0 29. 00 HOME HEALTH AGENCY 116. 00 12, 249 0 30. 00 PHYSICI ANS' PRI VATE OFFICES 192. 00 36, 727 0 31. 00 THE WATERS 194. 09 5, 959 0 32. 00 HENRY COUNTY RADI OLOGY 194. 14 3, 992 0 TOTALS 1, 301, 529 0 I - MEDI CAL DI RECTOR RECLASS 1. 00 NURSI NG ADMI NI STRATI ON 25, 000 0 J - VERO RECLASS 1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 6, 640 TOTALS 0 6, 640 L - MED SUPPLIES RECLASS 1. 00 MEDI CAL SUPPLIES CHARGED TO 71. 00 0 10, 159, 885 PATI ENTS | | | | | - | | | 25. 00 |
| 27. 00 EMERGENCY 91. 00 69, 204 0 228. 00 HOME HEALTH AGENCY 101. 00 27, 186 0 229. 00 HOSPI CE 116. 00 12, 249 0 229. 00 HOSPI CE 116. 00 12, 249 0 229. 00 HOSPI CE 116. 00 12, 249 0 36. 727 0 37. 00 37. 00 HEART S 194. 09 5, 959 0 37. 00 37. 00 HEART COUNTY RADI OLOGY 194. 14 3, 992 0 1 1 - MEDI CAL DI RECTOR RECLASS 11. 00 NURSI NG ADMI NI STRATI ON 13. 00 25, 000 0 1 - VERO RECLASS 1. 00 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 6, 640 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | | | | | | | 26.00 |
| 28. 00 HOME HEALTH AGENCY 101. 00 27, 186 0 29. 00 HOSPI CE 116. 00 12, 249 0 220 30. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 36, 727 0 31. 00 THE WATERS 194. 09 5, 959 0 32. 00 HENRY COUNTY RADI OLOGY 194. 14 3, 992 0 TOTALS 1, 301, 529 0 1 - MEDI CAL DI RECTOR RECLASS 1. 00 NURSI NG ADMI NI STRATI ON 25, 000 0 J - VERO RECLASS 1. 00 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 6, 640 TOTALS 0 6, 640 TOTALS 0 6, 640 TOTALS 0 6, 640 TOTALS 0 71. 00 0 10, 159, 885 PATI ENTS | | | | | | | | 27. 00 |
| 29. 00 HOSPI CE 116. 00 12, 249 0 26 30. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 36, 727 0 31. 00 THE WATERS 194. 09 5, 959 0 33. 32. 00 HENRY COUNTY RADI OLOGY 194. 14 3, 992 0 TOTALS 1, 301, 529 0 1 - MEDI CAL DI RECTOR RECLASS 1. 00 NURSI NG ADMI NI STRATI ON 13. 00 25, 000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 1 | | | | | | 28. 00 |
| 31. 00 THE WATERS 194. 09 5, 959 0 32. 00 HENRY COUNTY RADIOLOGY 194. 14 3, 992 0 TOTALS 1, 301, 529 0 1 - MEDI CAL DI RECTOR RECLASS 1. 00 NURSI NG ADMI NI STRATI ON 25, 000 0 J - VERO RECLASS 1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 6, 640 TOTALS 0 6, 640 TOTALS 1. 00 MEDI CAL SUPPLIES RECLASS 1. 00 MEDI CAL SUPPLIES CHARGED TO 71. 00 0 10, 159, 885 PATI ENTS | | | | | 0 | | | 29. 00 |
| 32. 00 HENRY COUNTY RADI OLOGY 194. 14 3, 992 0 TOTALS 1, 301, 529 0 I - MEDI CAL DI RECTOR RECLASS 1. 00 NURSI NG ADMI NI STRATI ON 25, 000 0 J - VERO RECLASS 1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 6, 640 0 L - MED SUPPLI ES RECLASS 1. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 10, 159, 885 0 PATI ENTS | | | | | - | | | 30.00 |
| TOTALS | | | | | | | | 31.00 |
| 1 - MEDI CAL DI RECTOR RECLASS 13.00 25,000 0 0 0 0 0 0 0 0 0 | 32. 00 | | 1 <u>94.</u> 14 | | 0 | | | 32.00 |
| 1. 00 NURSI NG ADMI NI STRATI ON 13. 00 25, 000 0 J - VERO RECLASS 1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 6, 640 TOTALS 0 6, 640 L - MED SUPPLIES RECLASS 1. 00 MEDI CAL SUPPLIES CHARGED TO 71. 00 0 10, 159, 885 PATI ENTS | | | | 1, 301, 529 | 0 | | | |
| J - VERO RECLASS | 1 00 | | 12 00 | 25 000 | | | | 1.00 |
| J - VERO RECLASS | 1.00 | 0 NOTING ADMINISTRATION | 13.00 | | [| | | 1.00 |
| 1. 00 | | J - VERO RECLASS | | 25,000 | U | | | |
| TOTALS 0 6, 640 L - MED SUPPLIES RECLASS 1. 00 MEDICAL SUPPLIES CHARGED TO 71. 00 0 10, 159, 885 PATIENTS 0 10, 159, 885 | 1. 00 | | 4. 00 | Ol | 6. 640 | | | 1. 00 |
| L - MED SUPPLIES RECLASS 1. 00 MEDICAL SUPPLIES CHARGED TO 71. 00 0 10, 159, 885 PATIENTS 0 10, 159, 885 | | TOTALS | — — ° \$ | | | | | 1.00 |
| 1. 00 MEDICAL SUPPLIES CHARGED TO 71. 00 0 10, 159, 885 PATIENTS | | | | | -, -, -, -, | | | |
| | 1. 00 | MEDICAL SUPPLIES CHARGED TO | 71. 00 | 0 | 10, 159, 885 | | | 1.00 |
| [0 0 10, 159, 885] | | | | | | | | |
| | | [0 | | 0 | 10, 159, 885 | | | |

Health Financial Systems RECLASSIFICATIONS HENRY COUNTY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-0030

Period: Worksheet A-6 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 3:43 pm

| | | | | | 5/26/2022 3: 4 | 3 pm |
|--------|-------------------------------|-----------|-------------|--------------|----------------|--------|
| | | Increases | | | | |
| | Cost Center | Li ne # | Sal ary | 0ther | | |
| | 2. 00 | 3. 00 | 4. 00 | 5. 00 | | |
| | M - FOREST RIDGE STAFF RECLAS | SS | | | | |
| 1.00 | RURAL HEALTH CLINIC | 88. 00 | 14, 931 | 0 | | 1.00 |
| 2.00 | RURAL HEALTH CLINIC II | 88. 01 | 228, 987 | 0 | | 2.00 |
| | 0 | | 243, 918 | | | |
| | O - BENEFIT RECLASS | | | | | |
| 1.00 | EMPLOYEE BENEFITS DEPARTMENT | 4. 00 | 0 | 3, 612, 475 | | 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 | O | 0 | | 11.00 |
| | 0 — — — — — | - $ +$ | | 3, 612, 475 | | |
| 500.00 | Grand Total: Increases | | 2, 889, 274 | 23, 012, 573 | | 500.00 |

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0030

| | | | | | То | 12/31/2021 Date/Time Prepar 5/26/2022 3:43 p | |
|------------------|--|------------------|------------------------------|-------------------------------|-------------------------|---|----------------|
| | Cook Cooker | Decreases | C-1 | 0+1 | WI-+ A 7 D-6 | | |
| | Cost Center 6.00 | Li ne # | Sal ary 8. 00 | 0ther 9.00 | Wkst. A-7 Ref. 10.00 | | |
| | A - OB/NURSERY/L&D | 7.00 | 0.00 | 7. 00 | 10.00 | | |
| 1.00 | ADULTS & PEDIATRICS | 30.00 | 781, 842 | 102, 748 | 0 | | 1.00 |
| 2.00 | | 000 | 0 | 0 | | | 2.00 |
| | 0 | | 781, 842 | 102, 748 | | | |
| 1. 00 | B - CAFETERI A DI ETARY | 10. 00 | 285, 851 | 175, 821 | 0 | | 1. 00 |
| 1.00 | 0 | | 26 <u>5, 651</u> 285, 851 | 17 <u>5, 6</u> 21 175, 821 | | | 1.00 |
| | C - WATERS EXCLUSIONS | I | 200,001 | 1707021 | L L | | |
| 1.00 | DI ETARY | 10. 00 | 251, 134 | <u>154, 4</u> 67 | 0 | | 1. 00 |
| | 0 | | 251, 134 | 154, 467 | | | |
| 1 00 | D - DEPRECIATION POB | 1 00 | | 00.004 | 9 | | 1 00 |
| 1. 00 | NEW CAP REL COSTS-BLDG & FLXT | 1. 00 | 0 | 88, 894 | 9 | | 1. 00 |
| | | + | | 88, 894 | | | |
| | E - EQUIPMENT RENTAL | | | | | | |
| 1.00 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 2, 768 | | | 1. 00 |
| 2.00 | NURSING ADMINISTRATION | 13.00 | 0 | 7, 948 | | | 2.00 |
| 3.00 | MEDICAL RECORDS & LIBRARY | 16. 00 | 0 | 120 | | 1 | 3.00 |
| 4. 00 5. 00 | ADULTS & PEDI ATRI CS RADI OLOGY-DI AGNOSTI C | 30. 00 54. 00 | 0 | 25, 763 322, 162 | | | 4. 00 5. 00 |
| 6. 00 | RESPIRATORY THERAPY | 65. 00 | 0 | 1, 471 | | | 6. 00 |
| 7. 00 | PHYSI CAL THERAPY | 66. 00 | O | 172 | | | 7. 00 |
| | 0 | | | 360, 404 | | | |
| | F - IMPLANTABLE DEVICES | | | | | | |
| 1. 00 | MEDICAL SUPPLIES CHARGED TO | 71. 00 | 0 | 8, 351, 239 | 0 | | 1. 00 |
| | PATI ENTS | + | | | | | |
| | G - BONUS RECLASS | | <u> </u> | 0,001,207 | | | |
| 1.00 | EMPLOYEE BENEFITS DEPARTMENT | 4. 00 | 1, 301, 529 | 0 | 0 | | 1. 00 |
| 2.00 | | 0. 00 | 0 | 0 | 0 | | 2.00 |
| 3.00 | | 0. 00 | 0 | 0 | | 1 | 3.00 |
| 4.00 | | 0. 00 | 0 | 0 | | | 4.00 |
| 5. 00 6. 00 | | 0. 00 0. 00 | 0 | 0 | | 1 | 5.00 |
| 7. 00 | | 0.00 | 0 | 0 | | 1 | 6. 00 7. 00 |
| 8. 00 | | 0.00 | 0 | 0 | | | 8. 00 |
| 9. 00 | | 0.00 | o | 0 | | | 9. 00 |
| 10.00 | | 0. 00 | 0 | 0 | 0 | | 0. 00 |
| 11. 00 | | 0. 00 | 0 | 0 | | 1 | 1. 00 |
| 12.00 | | 0. 00 | 0 | 0 | | 1 | 2.00 |
| 13.00 | | 0. 00 | 0 | 0 | | 1 | 3.00 |
| 14. 00 15. 00 | | 0. 00 0. 00 | 0 | 0 | | 1 | 4. 00 5. 00 |
| 16. 00 | | 0.00 | 0 | 0 | | | 6. 00 |
| 17. 00 | | 0.00 | o | 0 | | | 7. 00 |
| 18. 00 | | 0.00 | O | 0 | 0 | 1 | 8. 00 |
| 19. 00 | | 0. 00 | 0 | 0 | 0 | | 9. 00 |
| 20.00 | | 0. 00 | 0 | 0 | 0 | | 0. 00 |
| 21.00 | | 0.00 | 0 | 0 | | | 1.00 |
| 22. 00 23. 00 | | 0. 00 0. 00 | 0 | 0 | | | 2. 00 3. 00 |
| 24. 00 | | 0.00 | 0 | 0 | | | 4. 00 |
| 25. 00 | | 0.00 | 0 | Ö | - | | 5. 00 |
| 26. 00 | | 0.00 | o | 0 | 0 | | 6. 00 |
| 27.00 | | 0. 00 | 0 | 0 | 0 | | 7. 00 |
| 28. 00 | | 0. 00 | 0 | 0 | 0 | | 8. 00 |
| 29. 00 | | 0.00 | 0 | 0 | | | 9. 00 |
| 30.00 | | 0. 00 | 0 | 0 | | | 0.00 |
| 31. 00 32. 00 | | 0. 00 0. 00 | 0 | 0 | | | 1. 00 2. 00 |
| 32.00 | TOTALS — — — — | | 1, 301, 529 | 0 | | 3. | 2.00 |
| | I - MEDICAL DIRECTOR RECLASS | | ., 55., 52. | | | | |
| 1.00 | PHYSICIANS' PRIVATE OFFICES | 192. 00 | 25, 000 | 0 | 0 | | 1. 00 |
| | 0 | | 25, 000 | 0 | | | |
| 4 00 | J - VERO RECLASS | 5 00 | | | | | |
| 1. 00 | ADMI NI STRATI VE & GENERAL | | 6,640 | 0 | 0 | | 1. 00 |
| | TOTALS L - MED SUPPLIES RECLASS | | 6, 640 | 0 | | | |
| 1. 00 | OPERATING ROOM | 50.00 | 0 | 10, 159, 885 | 0 | | 1. 00 |
| 50 | 0 | | | 10, 159, 885 | | | 55 |
| | M - FOREST RIDGE STAFF RECLASS | | | | | | |
| 1.00 | RURAL HEALTH CLINIC | 88. 00 | 228, 987 | 0 | | | 1.00 |
| 2. 00 | PHYSICIANS' PRIVATE OFFICES | 1 <u>92.</u> 00 | 14, 931 | 0 | 0 | 2 | 2. 00 |
| | <u> </u> | | 243, 918 | 0 | 1 | | |

Health Financial Systems RECLASSIFICATIONS

HENRY COUNTY MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-0030

Peri od: Worksheet A-6 From 01/01/2021 To 12/31/2021 Date/Time Prepared:

| | | | | | | 5/26/2022 3: 4 | 13 pm |
|--------|-----------------------------|-----------|-------------|--------------|----------------|----------------|--------|
| | | Decreases | | | | | |
| | Cost Center | Li ne # | Sal ary | 0ther | Wkst. A-7 Ref. | | |
| | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | | |
| | O - BENEFIT RECLASS | | | | | | i |
| 1.00 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 1, 058 | 0 | | 1.00 |
| 2.00 | PHARMACY | 15. 00 | 0 | 206, 772 | 0 | | 2.00 |
| 3.00 | ADULTS & PEDIATRICS | 30.00 | 0 | 14, 939 | 0 | | 3.00 |
| 4.00 | OPERATING ROOM | 50.00 | 0 | 395, 616 | 0 | | 4.00 |
| 5.00 | RURAL HEALTH CLINIC | 88. 00 | 0 | 1, 083, 153 | 0 | | 5.00 |
| 6.00 | RURAL HEALTH CLINIC II | 88. 01 | 0 | 1, 696, 699 | 0 | | 6.00 |
| 7.00 | RURAL HEALTH CLINIC III | 88. 02 | 0 | 119, 171 | 0 | | 7.00 |
| 8.00 | HOME HEALTH AGENCY | 101.00 | 0 | 12, 741 | 0 | | 8.00 |
| 9.00 | HOSPI CE | 116. 00 | 0 | 5, 722 | 0 | | 9.00 |
| 10.00 | PHYSICIANS' PRIVATE OFFICES | 192. 00 | 0 | 74, 735 | 0 | | 10.00 |
| 11.00 | HENRY COUNTY RADIOLOGY | 194. 14 | 0 | 1, 869 | 0 | | 11.00 |
| | 0 | | 0 | 3, 612, 475 | | | i |
| 500.00 | Grand Total: Decreases | | 2, 895, 914 | 23, 005, 933 | | | 500.00 |

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

7.00

8.00

9.00

7.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0030 Peri od: Worksheet A-7 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 3:43 pm Acqui si ti ons Begi nni ng Purchases Total Disposals and Donati on Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 46, 000 Land 0 1.00 0 0 Land Improvements 2, 112, 571 2.00 0 597, 769 2.00 3.00 Buildings and Fixtures 42, 082, 284 2, 377, 024 C 3.00 0 4.00 Building Improvements 1, 898, 222 C 4.00 Fi xed Equi pment 22, 759, 639 0 781, 462 5.00 5.00 38, 261, 372 0 6.00 Movable Equipment 1, 994, 041 1, 994, 041 6.00 0 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 107, 160, 088 1, 994, 041 0 1, 994, 041 3, 756, 255 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 107, 160, 088 1, 994, 041 1, 994, 041 3, 756, 255 10.00 O 10.00 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 46,000 0 1.00 2.00 1, 514, 802 0 2.00 Land Improvements 3.00 Buildings and Fixtures 39, 705, 260 0 3.00 4.00 Building Improvements 1, 898, 222 0 4.00 5.00 Fixed Equipment 21, 978, 177 0 5.00 Movable Equipment 0 6.00 40, 255, 413 6.00

105, 397, 874

105, 397, 874

0

0

0

0

| Heal th | Financial Systems HE | ENRY COUNTY MEM | ORIAL HOSPITAL | | In Lieu of Form CMS-2552-10 | | |
|---|--|--------------------|-----------------|----------|---|--------------------------|--------|
| RECON | CILIATION OF CAPITAL COSTS CENTERS | | Provider CO | | Period: From 01/01/2021 Fo 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 WORKSHEET A, COLUMN 2, LINES 1 and 2 | | | | | | | |
| 1. 00 | NEW CAP REL COSTS-BLDG & FIXT | 5, 229, 786 | 0 | 162, 76 | 7 0 | 0 | 1.00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | 0 | (| 0 | 0 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 5, 229, 786 | | 162, 76 | 7 0 | 0 | 3.00 |
| | | SUMMARY 0 | F CAPITAL | | | | |
| | Cost Center Description | Other | Total (1) | | | | |
| | | Capi tal -Rel at | (sum of cols. | | | | |
| | | ed Costs (see | 9 through 14) | | | | |
| | | instructions) | | | | | |
| | | 14. 00 | 15. 00 | | | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLUM | MN 2, LINES 1 a | and 2 | | | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 0 | 5, 392, 553 | | | | 1.00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | 0 | | | | 2.00 |
| 3. 00 | Total (sum of lines 1-2) | 0 | 5, 392, 553 | | | | 3. 00 |
| | | | | | | | |

| Heal th | n Financial Systems HE | ENRY COUNTY MEM | IORIAL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|---------------------|--------------------------|---|--|-----------------|---------|
| | CILIATION OF CAPITAL COSTS CENTERS | | | F | Peri od: From 01/01/2021 Part III To 12/31/2021 Date/Time Pr 5/26/2022 3: | | pared: |
| | | COMF | PUTATION OF RAT | TI OS | ALLOCATION OF | OTHER CAPITAL | |
| | Cost Center Description | Gross Assets | Capi tal i zed Leases | Gross Assets for Ratio (col. 1 - col. 2) | Ratio (see instructions) | Insurance | |
| | | 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 | 65, 142, 461 | 0 | 65, 142, 461 | 0. 618062 | 0 | 1.00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 40, 255, 413 | 0 | 40, 255, 413 | 0. 381938 | 0 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 105, 397, 874 | 0 | 105, 397, 874 | 1.000000 | 0 | 3.00 |
| | | ALLOCA ⁻ | TION OF OTHER (| CAPI TAL | SUMMARY O | F CAPITAL | |
| | Cost Center Description | Taxes | Other | Total (sum of | Depreciation | Lease | |
| | | | Capi tal -Rel at | cols. 5 | | | |
| | | | ed Costs | through 7) | | | |
| | | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS C | ENTERS | | | | | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 0 | 0 | (| 5, 140, 892 | 0 | 1.00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | 0 | (| 360, 404 | 0 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | 0 | (| 5, 501, 296 | 0 | 3.00 |
| | | | SL | JMMARY OF CAPI | ΓAL | | |
| | Cost Center Description | Interest | Insurance | Taxes (see | Other | Total (2) | |
| | | | (see | instructions) | Capi tal -Rel at | (sum of cols. | |
| | | | instructions) | , | ed Costs (see instructions) | | |

11.00

42, 938 0 42, 938

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

1.00 NEW CAP REL COSTS-BLDG & FIXT
2.00 NEW CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

12. 00

0 0 0 13.00

0 0 0 14.00

0 0

15.00

5, 183, 830 1.00 360, 404 2.00 5, 544, 234 3.00

Provider CCN: 15-0030 Worksheet A-8 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 3:43 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Cost Center Description Amount Line # Wkst. A-7 (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - NEW CAP Α -119,829 NEW CAP REL COSTS-BLDG & 1.00 1.00 REL COSTS-BLDG & FLXT (chapter FLXT 2.00 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter EQUI P 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 -10, 398 ADMINISTRATIVE & GENERAL Trade, quantity, and time В 5.00 4.00 discounts (chapter 8) Refunds and rebates of 5.00 0 0.00 5.00 expenses (chapter 8) 6 00 Rental of provider space by 0 00 6 00 suppliers (chapter 8) 7.00 Tel ephone services (pay -28, 147 ADMINISTRATIVE & GENERAL 5.00 7.00 Α stations excluded) (chapter 21) 8.00 Television and radio service 0 8.00 0.00 (chapter 21) Parking lot (chapter 21) 9.00 0.00 9.00 10.00 Provi der-based physici an A-8-2 -6, 976, 399 10.00 adjustment Sale of scrap, waste, etc. 11.00 0.00 11.00 (chapter 23) 12.00 Related organization A-8-1 -2, 725, 222 12.00 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 -259, 708 CAFETERI A 14 00 Cafeteria-employees and guests В 11 00 O 14 00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 0 0.00 16.00 supplies to other than pati ents Sale of drugs to other than 17.00 0.00 17.00 pati ents 18.00 Sale of medical records and -6, 188 MEDICAL RECORDS & LIBRARY 18.00 В 16.00 abstracts 19.00 Nursing and allied health 19.00 0.00 0 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 24.00 66.00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review -OUTILIZATION REVIEW-SNE 114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 1.00 26.00 COSTS-BLDG & FLXT
Depreciation - NEW CAP REL IFI XT ONEW CAP REL COSTS-MVBLE 27.00 27.00 2.00 COSTS-MVBLE EQUIP FOUL P 28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 Physicians' assistant 29.00 29.00 0.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 30.00 30.00 67.00 therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions)

Provider CCN: 15-0030 Peri od: Worksheet A-8 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 3:43 pm

| | | | | Expense Classification on | | 5/20/2022 3:4 | 3 piii |
|--------|--------------------------------|----------------|----------------|--------------------------------|----------------|---------------|--------|
| | | | | | | | |
| | | | | To/From Which the Amount is | to be Adjusted | | |
| | | | | | • | | |
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| | | | | | | | |
| | | | | | | | |
| | Cost Center Description | Basi s/Code | Amount | Cost Center | Li ne # | Wkst. A-7 | |
| | | (2) | | | | Ref. | |
| | | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| 21 00 | Ad:++ | A-8-3 | | | | 5.00 | 21 00 |
| 31. 00 | ., | A-8-3 | Ü | SPEECH PATHOLOGY | 68. 00 | | 31.00 |
| | pathology costs in excess of | | | | | | |
| | limitation (chapter 14) | | | | | | |
| 32.00 | CAH HIT Adjustment for | | 0 | | 0. 00 | 0 | 32.00 |
| | Depreciation and Interest | | | | | | |
| 33.00 | OTHER OP REV - HUMAN RESOURSEC | В | _152 | EMPLOYEE BENEFITS DEPARTMENT | 4. 00 | 0 | 33.00 |
| 33.00 | - MIS | Ь | 132 | LW LOTEL DENETTTO DEL ARTIMENT | 4.00 | 0 | 33.00 |
| 22 01 | 1 - | В | 42 110 | ADMINISTRATIVE & CENEDAL | Г 00 | 0 | 22 01 |
| 33. 01 | OTHER OP REV - PHY REAPP FEES | | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 00.0. |
| 33. 02 | OTHER OP REV | В | 600 | HOUSEKEEPI NG | 9. 00 | 0 | 33. 02 |
| 33. 03 | DI ETARY-OTHER OP REV | В | -28, 434 | DI ETARY | 10.00 | 0 | 33. 03 |
| 33.04 | OTHER OP REV - PHARMACY | В | -804, 500 | PHARMACY | 15. 00 | 0 | 33. 04 |
| 33. 05 | OTHER OP REV - LABORATORY-LAB | В | | LABORATORY | 60.00 | 0 | 33. 05 |
| 00.00 | DRUG S | 5 | 2, 201 | LABORATORT | 00.00 | J | 00.00 |
| 33. 06 | 1 | В | 00 222 | DUVCI CAL THEDADY | 66. 00 | 0 | 33.06 |
| 33.06 | OTHER OP REV - AQUATICS - HLTH | В | -88, 222 | PHYSI CAL THERAPY | 00.00 | U | 33.06 |
| | PROG | _ | | | | _ | |
| 33. 07 | OTHER OP REV - NORTHFIELD PARK | В | | RURAL HEALTH CLINIC II | 88. 01 | 0 | 33. 07 |
| 33. 08 | PUBLIC RELATIONS | Α | -5, 126 | EMPLOYEE BENEFITS DEPARTMENT | 4. 00 | 0 | 33. 08 |
| 33. 09 | PUBLIC RELATIONS | Α | -167, 144 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 09 |
| 33. 10 | PUBLIC RELATIONS | Α | -618 | NURSING ADMINISTRATION | 13. 00 | 0 | 33. 10 |
| 33. 11 | PUBLIC RELATIONS | A | | RADI OLOGY-DI AGNOSTI C | 54. 00 | 0 | 1 |
| 33. 12 | PUBLIC RELATIONS | A | · · | RURAL HEALTH CLINIC | 88. 00 | 0 | 33. 12 |
| | | | | | | 0 | |
| 33. 13 | PUBLIC RELATIONS | Α | | RURAL HEALTH CLINIC II | 88. 01 | 0 | |
| 33. 14 | PUBLIC RELATIONS | Α | -56, 022 | RURAL HEALTH CLINIC III | 88. 02 | 0 | 33. 14 |
| 33. 15 | PUBLIC RELATIONS | Α | -1, 764 | EMERGENCY | 91. 00 | 0 | 33. 15 |
| 33. 16 | PUBLIC RELATIONS | Α | -300 | HOME HEALTH AGENCY | 101.00 | 0 | 33. 16 |
| 33. 17 | PUBLIC RELATIONS | Α | | HOSPI CE | 116. 00 | 0 | 33. 17 |
| 33. 18 | AHA & I HA DUES | A | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 18 |
| | 1 | | | | | _ | |
| 33. 19 | BENEFIT EXPENSE | A | | EMPLOYEE BENEFITS DEPARTMENT | 4. 00 | 0 | 33. 19 |
| 33. 20 | NC FAMILY INTERNAL | В | -97, 800 | RURAL HEALTH CLINIC | 88. 00 | 0 | 33. 20 |
| | MEDICINE-OTHER OP | | | | | | |
| 33. 21 | MEDICAL DIRECTOR | Α | 90, 000 | NURSING ADMINISTRATION | 13. 00 | 0 | 33. 21 |
| 33. 22 | HAF EXPENSE | Α | -4, 369, 044 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 22 |
| 33. 23 | PHYSI CI AN RECRUI TMENT | A | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | |
| 33. 24 | PHYSI CI AN RECRUITMENT | Ä | | OPERATI NG ROOM | 50.00 | 0 | 33. 24 |
| | | A | | | 50.00 | 0 | 1 |
| 50.00 | TOTAL (sum of lines 1 thru 49) | | -13, 088, 513 | | | | 50.00 |
| | (Transfer to Worksheet A, | | | | | | |
| | column 6, line 200.) | | | | | | |
| (1) Do | scription all chapter referen | 000 in this 00 | lumn nontoin t | a CMC Dub. 1E 1 | | | _ |

⁽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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME | Provider CCN: 15-0030

Period: Worksheet A-8-1

| OFFICE | COSTS | | | From 01/01/2021 | | |
|--------|-------------------------------|-------------------------------|-----------------------------|-----------------|----------------|-------|
| | | | | To 12/31/2021 | | |
| | Line No | Coot Contor | Evnance I tomo | Amount of | 5/26/2022 3: 4 | 3 pm |
| | Li ne No. | Cost Center | Expense Items | Amount of | Amount | |
| | | | | Allowable Cost | | |
| | | | | | Wks. A, column | |
| | 1.00 | 0.00 | 2.00 | 4.00 | 5 | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5. 00 | |
| | A. COSTS INCURRED AND ADJUSTI | MENTS REQUIRED AS A RESULT OF | TRANSACTIONS WITH RELATED C | RGANIZATIONS OF | CLAIMED HOME | |
| 4 00 | OFFICE COSTS: | ADMINISTRATIVE & CENEDAL | DENT EVDENCE | | 45.000 | 4 00 |
| 1.00 | 1 | | RENT EXPENSE | 0 | 15, 002 | 1.00 |
| 2. 00 | 1 | | RENT EXPENSE | 9, 156 | | 2.00 |
| 3.00 | | l . | RENT EXPENSE | 10, 872 | | 3. 00 |
| 3. 01 | | CT SCAN | RENT EXPENSE | 218, 066 | | 3. 01 |
| 3. 02 | | | RENT EXPENSE | 164, 833 | | 3. 02 |
| 4.00 | 60.00 | LABORATORY | RENT EXPENSE | 6, 201 | 34, 687 | 4.00 |
| 4. 01 | 65. 00 | RESPI RATORY THERAPY | RENT EXPENSE | 24, 020 | 0 | 4. 01 |
| 4.02 | 66.00 | PHYSI CAL THERAPY | RENT EXPENSE | 178, 725 | 751, 297 | 4.02 |
| 4.03 | 88.00 | RURAL HEALTH CLINIC | RENT EXPENSE | 239, 831 | 522, 525 | 4.03 |
| 4.04 | 88. 01 | RURAL HEALTH CLINIC II | RENT EXPENSE | 619, 424 | 1, 290, 739 | 4.04 |
| 4.05 | 88. 02 | RURAL HEALTH CLINIC III | RENT EXPENSE | 66, 293 | 152, 593 | 4.05 |
| 4.06 | 101.00 | HOME HEALTH AGENCY | RENT EXPENSE | 7, 438 | 22, 481 | 4.06 |
| 4. 07 | 116.00 | HOSPI CE | RENT EXPENSE | 7, 435 | 22, 480 | 4.07 |
| 4. 08 | 192.00 | PHYSICIANS' PRIVATE OFFICES | RENT EXPENSE | 2, 617 | | 4.08 |
| 5.00 | TOTALS (sum of lines 1-4). | | | 1, 554, 911 | | 5.00 |
| | Transfer column 6, line 5 to | | | | | |
| | Worksheet A-8, column 2, | | | | | |
| | line 12. | | | | | |
| * TI. | | | | | | |

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

| | | | Related Organization(s) and | or Home Office | | | |
|---|-------|---------------|-----------------------------|----------------|--|--|--|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Symbol (1) | Name | Percentage of | Name | Percentage of | | | |
| • | | Ownershi p | | Ownershi p | | | |
| 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | | | |
| B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: | | | | | | | |

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

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

| 6. 00 | G | HENRY COUNTY HO | 100.00 | HOSPITAL FOUNDA | 100.00 | 6.00 |
|--------|-------------------------|-----------------|--------|-----------------|--------|--------|
| 7.00 | | | 0.00 | | 0.00 | 7. 00 |
| 8. 00 | | | 0.00 | | 0.00 | 8. 00 |
| 9. 00 | | | 0.00 | | 0.00 | 9. 00 |
| 10.00 | | | 0.00 | | 0.00 | 10.00 |
| 100.00 | G. Other (financial or | MI SC | | | | 100.00 |
| | non-financial) specify: | | | | | |

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

4.00

4.01

4.02

4 03

4.04

4.05

4.06

4.07

4.08

5.00 -2, 725, 222 5.00 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

| nas no | t been posted to worksheet A, | cordinis i and/or 2, the amount arrowable should be mareated in cordinir 4 or this part | |
|--------|-------------------------------|---|--|
| | Rel ated Organi zation(s) | | |
| | and/or Home Office | | |
| | | | |
| | | | |
| | Type of Business | | |
| | | | |
| | 6.00 | | |
| | B. INTERRELATIONSHIP TO RELA | TED ORGANIZATION(S) AND/OR HOME OFFICE: | |
| | | | |

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

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

| 6.00 | MI SC | 6.00 |
|-----------------------------------|-------|--------------|
| 7.00 | | 7.00 |
| 8.00 | | 8.00 9.00 |
| 9.00 | | 9.00 |
| 10.00 | | 10.00 |
| 7. 00 8. 00 9. 00 10. 00 | | 100.00 |

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

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

4.00

4.01

4.02

4.03

4.04

4.05

4.06

4.07

4.08

-28, 486

24,020

-572, 572

-282, 694

-671, 315

-86, 300

-15.043

-15,045

-46, 133

0

0

0

0

0

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 01/01/2021 To 12/31/2021 Date/Time Prepared: Provider CCN: 15-0030

| | | | | | | Го 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
|--------|----------------|------------------------|----------------|----------------|-----------------|---------------|-----------------------------|---------|
| | Wkst. A Line # | Cost Center/Physician | Total | Professi onal | Provi der | RCE Amount | Physi ci an/Prov | |
| | | I denti fi er | Remuneration | Component | Component | | ider Component | |
| | | | | | | | Hours | |
| | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | 6. 00 | 7. 00 | |
| 1.00 | | NURSING ADMINISTRATION | 25, 000 | | | | 260 | 1.00 |
| 2.00 | | ADULTS & PEDIATRICS | 2, 307, 523 | | | 2,000 | 0 | 2.00 |
| 3.00 | 50.00 | OPERATING ROOM | 3, 306, 701 | 3, 287, 794 | 18, 907 | 246, 400 | 180 | 3.00 |
| 4.00 | | LABORATORY | 56, 000 | | 56, 000 | 211, 500 | 553 | 4.00 |
| 5.00 | 88. 01 | RURAL HEALTH CLINIC II | 1, 348, 024 | 1, 348, 024 | | 211, 500 | 0 | 5.00 |
| 6.00 | 91.00 | EMERGENCY | 90, 000 | 0 | 90, 000 | 211, 500 | 560 | 6.00 |
| 7.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 7.00 |
| 8.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 8. 00 |
| 9. 00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 9. 00 |
| 10.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 10.00 |
| 200.00 | | | 7, 133, 248 | 6, 943, 341 | 189, 907 | | 1, 553 | |
| | Wkst. A Line # | Cost Center/Physician | Unadjusted RCE | | Cost of | | Physician Cost | |
| | | l denti fi er | Limit | Unadjusted RCE | | | of Malpractice | |
| | | | | Limit | Conti nui ng | Share of col. | Insurance | |
| | | | | | Educati on | 12 | | |
| | 1.00 | 2. 00 | 8. 00 | 9. 00 | 12. 00 | 13. 00 | 14. 00 | |
| 1. 00 | | NURSING ADMINISTRATION | 26, 438 | | | - | 0 | 1.00 |
| 2. 00 | | ADULTS & PEDIATRICS | 0 | | | | 0 | |
| 3. 00 | | OPERATING ROOM | 21, 323 | | | 1 | 0 | 3. 00 |
| 4. 00 | | LABORATORY | 56, 230 | | | 1 | 0 | 4. 00 |
| 5.00 | | RURAL HEALTH CLINIC II | 0 | 0 | _ | 0 | 0 | 5. 00 |
| 6. 00 | | EMERGENCY | 56, 942 | 2, 847 | 0 | 0 | 0 | 6. 00 |
| 7. 00 | 0. 00 | | 0 | 0 | 0 | 0 | 0 | 7. 00 |
| 8. 00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 8. 00 |
| 9. 00 | 0. 00 | 1 | 0 | 0 | 0 | 0 | 0 | 9. 00 |
| 10.00 | 0. 00 | | 0 | 0 | 0 | 1 | 0 | 10.00 |
| 200.00 | | 0 1 0 1 (8) | 160, 933 | | | | 0 | 200. 00 |
| | Wkst. A Line # | | Provi der | Adjusted RCE | RCE | Adjustment | | |
| | | l denti fi er | Component | Limit | Di sal I owance | | | |
| | | | Share of col. | | | | | |
| | 1. 00 | 2.00 | 15. 00 | 16. 00 | 17. 00 | 18. 00 | | |
| 1. 00 | 13 00 | NURSING ADMINISTRATION | 13.00 | 26, 438 | | | | 1. 00 |
| 2. 00 | | ADULTS & PEDIATRICS | 1 0 | 0 | | 1 | | 2. 00 |
| 3. 00 | | OPERATING ROOM | 1 0 | 21, 323 | _ | | | 3. 00 |
| 4. 00 | | LABORATORY | 1 0 | 56, 230 | | | | 4. 00 |
| 5. 00 | | RURAL HEALTH CLINIC II | | 00, 230 | | | | 5. 00 |
| 6. 00 | | EMERGENCY | 1 | 56, 942 | _ | | | 6. 00 |
| 7. 00 | 0.00 | | | 00, 742 0 | 33, 030 | 1 | | 7. 00 |
| 8. 00 | 0.00 | | | 0 | | | | 8. 00 |
| 9. 00 | 0.00 | | | | | | | 9. 00 |
| 10.00 | 0.00 | 1 | | | | 1 | | 10.00 |
| 200.00 | • | | | 160, 933 | _ | | | 200.00 |
| 200.00 | ı | I | 1 | 1 100, 700 | 1 33, 030 | 0, 7,0,077 | | 230.00 |

| Peri od: | Worksheet B | From 01/01/2021 | Part | | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0030

| | | | | | To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
|-----------------------|--|------------------------------|-----------------------|--------------------|--------------------------|-----------------------------|------------------|
| | | | CAPITAL RELATED COSTS | | | 5/20/2022 3.4 | 3 piii |
| | | | NEW DI DO A | 1 115111 111/151 5 | 511D1 01/55 | | |
| | Cost Center Description | Net Expenses for Cost | NEW BLDG & FLXT | NEW MVBLE EQUIP | EMPLOYEE BENEFITS | Subtotal | |
| | | Allocation | 1171 | 2011 | DEPARTMENT | | |
| | | (from Wkst A | | | | | |
| | | col. 7) 0 | 1 00 | 2.00 | 4.00 | 4.0 | |
| GF | NERAL SERVICE COST CENTERS | 0 | 1. 00 | 2. 00 | 4. 00 | 4A | |
| 1.00 00 | 0100 NEW CAP REL COSTS-BLDG & FIXT | 5, 183, 830 | 5, 183, 830 | | | | 1.00 |
| | 0200 NEW CAP REL COSTS-MVBLE EQUIP | 360, 404 | | 360, 40 | | | 2.00 |
| | 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL | 17, 662, 219 15, 338, 619 | 34, 124 730, 581 | 2, 24 48, 12 | | 18, 257, 170 | 4. 00 5. 00 |
| 4 | 0700 OPERATION OF PLANT | 3, 352, 597 | 1, 345, 777 | | | 5, 259, 874 | 7.00 |
| | 0800 LAUNDRY & LINEN SERVICE | 464, 136 | 67, 246 | | | 535, 812 | 8. 00 |
| | 1990 HOUSEKEEPI NG | 983, 148 | 39, 058 | | | 1, 024, 779 | 9.00 |
| | 000 DI ETARY 100 CAFETERI A | 530, 547 208, 746 | 141, 882 38, 763 | | | 792, 449 342, 813 | 10.00 11.00 |
| | 300 NURSING ADMINISTRATION | 3, 038, 354 | 80, 946 | | | 3, 946, 096 | 13.00 |
| | 400 CENTRAL SERVICES & SUPPLY | 1, 076, 375 | 140, 604 | 9, 26 | | 1, 411, 316 | 14.00 |
| | 500 PHARMACY | 4, 729, 943 | 30, 704 | | | 4, 762, 670 | 15.00 |
| | 600 MEDICAL RECORDS & LIBRARY PATIENT ROUTINE SERVICE COST CENTERS | 871, 637 | 20, 522 | 1, 35 | 2 228, 602 | 1, 122, 113 | 16.00 |
| | 3000 ADULTS & PEDIATRICS | 6, 685, 667 | 572, 659 | 37, 72 | 1, 919, 088 | 9, 215, 137 | 30.00 |
| | 100 INTENSIVE CARE UNIT | 2, 725, 171 | 228, 038 | | | 3, 565, 966 | 31.00 |
| | 300 NURSERY | 686, 829 | 60, 307 | 3, 97 | 3 192, 926 | 944, 035 | 43.00 |
| | ICILLARY SERVICE COST CENTERS OOO OPERATING ROOM | 4, 272, 640 | 420, 084 | 27, 67 | 2 1, 843, 917 | 6, 564, 313 | 50.00 |
| | 5200 DELIVERY ROOM & LABOR ROOM | 216, 311 | 30, 645 | | | 309, 735 | 52.00 |
| | 400 RADI OLOGY-DI AGNOSTI C | 2, 804, 222 | 222, 553 | | | 3, 705, 538 | 54.00 |
| | 700 CT SCAN | 553, 283 | 8, 610 | | | 630, 236 | 57.00 |
| | 800 MAGNETIC RESONANCE IMAGING (MRI) 8900 CARDIAC CATHETERIZATION | 353, 389 0 | 10, 516 | 69 | | 413, 174 0 | 58. 00 59. 00 |
| | 5000 LABORATORY | 5, 850, 345 | 162, 384 | 10, 69 | ١ | 6, 724, 470 | |
| 4 | 0001 BLOOD LABORATORY | 0 | 0 | ı | 0 | 0 | 60. 01 |
| | 5500 RESPI RATORY THERAPY | 1, 446, 087 | 48, 552 | 3, 19 | | 1, 783, 635 | 65.00 |
| | 600 PHYSICAL THERAPY 6700 OCCUPATIONAL THERAPY | 1, 613, 633 249, 831 | 21, 092 3, 420 | | | 2, 070, 309 327, 260 | 66. 00 67. 00 |
| 4 | 8800 SPEECH PATHOLOGY | 93, 517 | 3, 794 | 250 | | 125, 270 | 68.00 |
| 69. 00 06 | 900 ELECTROCARDI OLOGY | 413, 573 | 0 | | | 480, 087 | 69.00 |
| | 1100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 1, 401, 099 | 0 | | 0 | 1, 401, 099 | 71.00 |
| | '200 IMPL. DEV. CHARGED TO PATIENT '300 DRUGS CHARGED TO PATIENTS | 8, 351, 239 0 | 0 | • | 0 0 | 8, 351, 239 0 | 72. 00 73. 00 |
| | 3950 CARDI AC REHAB | 192, 852 | 13, 976 | | - | 262, 389 | 76.00 |
| OU | TPATIENT SERVICE COST CENTERS | | · | | | | |
| | 8800 RURAL HEALTH CLINIC | 5, 483, 649 | 0 | 1 | 1, 473, 023 | 6, 956, 672 | 88.00 |
| | 8801 RURAL HEALTH CLINIC II 8802 RURAL HEALTH CLINIC III | 9, 198, 149 1, 057, 151 | 0 | 1 | 2, 754, 843 256, 869 | 11, 952, 992 1, 314, 020 | 88. 01 88. 02 |
| | 2100 EMERGENCY | 5, 163, 705 | 207, 732 | | | 6, 331, 527 | 91.00 |
| | 2200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | 0 | 92.00 |
| 0T | HER REIMBURSABLE COST CENTERS | 1 402 754 | 0 | <u> </u> | 271 701 | 1 0/5 525 | 101 00 |
| | D100 HOME HEALTH AGENCY DECLAL PURPOSE COST CENTERS | 1, 493, 754 | 0 | | 0 371, 781 | 1, 865, 535 | 101.00 |
| | 300 I NTEREST EXPENSE | | | | | | 113.00 |
| | 400 UTILIZATION REVIEW-SNF | | | | | | 114.00 |
| 116. 00 11 118. 00 | 600 HOSPI CE | 722, 099 114, 828, 750 | 0 4 494 E40 | | 167, 512 17, 060, 257 | 889, 611 | • |
| | SUBTOTALS (SUM OF LINES 1 through 117) NREIMBURSABLE COST CENTERS | 114, 828, 750 | 4, 684, 569 | 308, 59 | J 17, 060, 257 | 113, 639, 341 |]118.00 |
| | 2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 17, 023 | 1, 12 | 1 0 | 18, 144 | 190.00 |
| | 2200 PHYSICIANS' PRIVATE OFFICES | 2, 070, 410 | 0 | | 502, 262 | 2, 572, 672 | |
| | 7950 HOSPI TALI ST | 0 004 | 0 | 19 02 | 0 | | 194.00 |
| | '951 RENTAL '955 OTHER NONREIMBURSABLE COSTS | 88, 894 206, 593 | 0 | 18, 92 | 0 | 107, 820 206, 593 | |
| | 7956 DR AFZAL | 7, 203 | 0 | | 0 | | 194.06 |
| | 7957 PHI LLI PS HALL | 0 | 0 | | 0 0 | | 194. 07 |
| | 7958 OB DRS | 0 | 402.220 | 21 7/ | 0 01 404 | | 194.08 |
| | 7959 THE WATERS 7960 CAMBRIDGE CITY | 411, 560 0 | 482, 238 0 | 31, 76 | 7 81, 486 0 0 | 1, 007, 051 0 | 194. 09 |
| 194. 11 07 | 961 WELL BEING | 469 | 0 | | 0 | | 194. 11 |
| | 7962 ACTIVATE HEALTH EMPLOYER CLINIC | 65, 512 | 0 | | 0 | 65, 512 | |
| | 7963 NEW CASTLE PEDIATRICS | 1 004 340 | 0 | ! | 0 | | 194. 13 |
| | 7964 HENRY COUNTY RADIOLOGY 7965 HENRY COUNTY ANESTHESIOLOGY | 1, 884, 368 0 | 0 | | 54, 586 | 1, 938, 954 0 | 194. 14 |
| | 7966 NEW CASTLE IMMEDICATE CARE & FAMILY | 0 | 0 | | | | 194. 16 |
| 200. 00 | Cross Foot Adjustments | | | | | 0 | 200. 00 |
| 201. 00 | Negative Cost Centers | 110 5/0 750 | 0 F 100 000 | 2/0 /0 | 0 | | 201.00 |
| 202. 00 | TOTAL (sum lines 118 through 201) | 119, 563, 759 | 5, 183, 830 | 360, 40 | 4 17, 698, 591 | 119, 563, 759 | 1202.00 |

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0030

| | | | | 1 | 0 12/31/2021 | Date/IIme Pre 5/26/2022 3:4 | |
|------------------|---|---------------------|---------------------|---------------|---------------|--------------------------------|--------------------|
| | Cost Center Description | ADMI NI STRATI V | OPERATI ON OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | S PIII |
| | | E & GENERAL | PLANT | LINEN SERVICE | 2.22 | 10.00 | |
| | GENERAL SERVICE COST CENTERS | 5. 00 | 7. 00 | 8.00 | 9. 00 | 10. 00 | |
| 1. 00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2. 00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5. 00 | 00500 ADMINISTRATIVE & GENERAL | 18, 257, 170 | | | | | 5.00 |
| 7. 00 | 00700 OPERATION OF PLANT | 947, 919 | 6, 207, 793 | 1 | | | 7. 00 |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | 96, 562 | 94, 842 | | l | | 8. 00 |
| 9.00 | 00900 HOUSEKEEPI NG | 184, 683 | 55, 086 | | | 4 407 440 | 9.00 |
| 10. 00 11. 00 | 01000 DI ETARY 01100 CAFETERI A | 142, 813 61, 781 | 200, 107 54, 671 | | | 1, 186, 448 0 | 10.00 11.00 |
| | 01300 NURSING ADMINISTRATION | 711, 154 | 114, 165 | 1 | 24, 413 | 0 | 13.00 |
| | 01400 CENTRAL SERVICES & SUPPLY | 254, 343 | 198, 305 | 1 | 42, 405 | 0 | 14.00 |
| | 01500 PHARMACY | 858, 314 | 43, 304 | • | 9, 260 | 0 | 15.00 |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY | 202, 224 | 28, 943 | 0 | 6, 189 | 0 | 16.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 | 03000 ADULTS & PEDI ATRI CS | 1, 660, 724 | 807, 665 | | | 928, 663 | 30.00 |
| | 03100 I NTENSI VE CARE UNI T | 642, 648 | 321, 619 | | | 257, 785 | 31.00 |
| 43. 00 | 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS | 170, 131 | 85, 055 | 10, 772 | 18, 188 | 0 | 43.00 |
| 50. 00 | 05000 OPERATING ROOM | 1, 183, 001 | 592, 477 | 130, 748 | 126, 694 | 0 | 50.00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 55, 820 | 43, 221 | | | 0 | 52.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 667, 801 | 313, 884 | | | 0 | 54.00 |
| 57. 00 | 05700 CT SCAN | 113, 579 | 12, 143 | 0 | 2, 597 | 0 | 57.00 |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 74, 461 | 14, 832 | | - ' | 0 | 58. 00 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | 0 | - | 0 | 59.00 |
| 60.00 | 06000 LABORATORY | 1, 211, 864 | 229, 023 | 1 | 48, 974 | 0 | 60.00 |
| 60. 01 65. 00 | 06001 BLOOD LABORATORY 06500 RESPIRATORY THERAPY | 321, 441 | 90, 378 | 0 | 19, 326 | 0 | 60. 01 65. 00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 373, 105 | 725, 965 | • | | 0 | 66.00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 58, 978 | 4, 824 | | | 0 | 67.00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 22, 576 | 5, 351 | | 1, 144 | 0 | 68.00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 86, 520 | 0 | 1 | o | 0 | 69.00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 252, 502 | 0 | 0 | 0 | 0 | 71.00 |
| 72. 00 | 07200 I MPL. DEV. CHARGED TO PATIENT | 1, 505, 035 | 0 | 0 | = | 0 | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | _ | 0 | 73.00 |
| | 03950 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS | 47, 287 | 19, 711 | 0 | 4, 215 | 0 | 76. 00 |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 1, 253, 711 | 437, 087 | 4, 521 | 93, 466 | 0 | 88. 00 |
| | 08801 RURAL HEALTH CLINIC II | 2, 154, 130 | 1, 129, 811 | | | 0 | 88. 01 |
| 88. 02 | 08802 RURAL HEALTH CLINIC III | 236, 809 | 141, 389 | | | 0 | 88. 02 |
| | 09100 EMERGENCY | 1, 141, 049 | 292, 981 | 130, 270 | 62, 651 | 0 | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | 00/ 004 | /0.407 | | 40.57/ | | 1.01.00 |
| | 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 336, 201 | 63, 487 | 0 | 13, 576 | 0 | 101.00 |
| | 11300 I NTEREST EXPENSE | | | | | | 113. 00 |
| | 11400 UTI LI ZATI ON REVI EW-SNF | | | | | | 114.00 |
| | 11600 HOSPI CE | 160, 323 | 63, 459 | 0 | 13, 570 | 0 | 116.00 |
| 118. 00 | | 17, 189, 489 | 6, 183, 785 | 571, 152 | 1, 290, 272 | 1, 186, 448 | |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 3, 270 | 24, 008 | 1 | 5, 134 | | 190.00 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 463, 639 | 0 | 0 | 0 | | 192. 00 194. 00 |
| | 07950 H0SPI TALI ST 07951 RENTAL | 0 19, 431 | 0 | | 0 | | 194.00 |
| | 07955 OTHER NONREI MBURSABLE COSTS | 37, 232 | 0 | 13, 580 | | | 194. 01 |
| | 07956 DR AFZAL | 1, 298 | 0 | 0 | Ö | | 194.06 |
| | 07957 PHILLIPS HALL | 0 | 0 | 5, 905 | Ö | | 194. 07 |
| | 07958 OB DRS | 0 | 0 | 9, 758 | | 0 | 194. 08 |
| | 07959 THE WATERS | 181, 488 | 0 | 126, 821 | 0 | | 194. 09 |
| | 07960 CAMBRI DGE CI TY | 0 | 0 | 0 | 0 | | 194. 10 |
| | 07961 WELL BEING | 85 | 0 | 0 | 0 | | 194. 11 |
| | 07962 ACTIVATE HEALTH EMPLOYER CLINIC | 11, 806 | 0 | 0 | 0 | | 194. 12 |
| | 07963 NEW CASTLE PEDIATRICS 07964 HENRY COUNTY RADIOLOGY | 349, 432 | 0 | | | | 194. 13 194. 14 |
| | 07965 HENRY COUNTY ANESTHESI OLOGY | 347, 432 N | 0 | | | | 194. 14 |
| | 07966 NEW CASTLE IMMEDICATE CARE & FAMILY | | n | ol o | l ől | | 194. 16 |
| 200.00 | | | · · | | | | 200.00 |
| 201. 00 | Negative Cost Centers | 0 | 0 | 0 | 0 | | 201.00 |
| 202. 00 | TOTAL (sum lines 118 through 201) | 18, 257, 170 | 6, 207, 793 | 727, 216 | 1, 295, 406 | 1, 186, 448 | 202.00 |
| | | | | | | | |

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0030

| | | | Ic | 12/31/2021 | Date/lime Pre 5/26/2022 3:4 | |
|---|--------------------|------------------------------|-----------------------|----------------|----------------------------------|--------------------|
| Cost Center Description | CAFETERI A | NURSI NG ADMI NI STRATI O | CENTRAL SERVICES & | PHARMACY | MEDI CAL RECORDS & | 3 piii |
| | | N | SUPPLY | | LI BRARY | |
| | 11. 00 | 13. 00 | 14.00 | 15.00 | 16.00 | |
| GENERAL SERVICE COST CENTERS | | | | | | |
| 1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT 5.00 OO500 ADMINISTRATIVE & GENERAL | | | | | | 4. 00 5. 00 |
| 7. 00 00700 OPERATION OF PLANT | | | | | | 7. 00 |
| 8. 00 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| 9. 00 00900 HOUSEKEEPI NG | | | | | | 9. 00 |
| 10. 00 01000 DI ETARY | | | | | | 10.00 |
| 11. 00 01100 CAFETERI A | 470, 956 | | | | | 11.00 |
| 13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY | 34, 115 | 4, 829, 943 | 1 01/ 000 | | | 13.00 |
| 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY | 10, 623 0 | 0 | 1, 916, 992 3, 175 | 5, 676, 723 | | 14. 00 15. 00 |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY | 20, 345 | o | 401 | 3, 070, 723 | 1, 380, 215 | 16. 00 |
| INPATIENT ROUTINE SERVICE COST CENTERS | 20,010 | <u> </u> | | <u> </u> | 1,000,210 | 10.00 |
| 30. 00 03000 ADULTS & PEDIATRICS | 87, 839 | 874, 633 | 43, 640 | 0 | 136, 185 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 29, 812 | 296, 854 | 17, 288 | 0 | 66, 509 | 31.00 |
| 43. 00 04300 NURSERY | 7, 494 | 74, 621 | 4, 031 | 0 | 38, 005 | 43.00 |
| ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM | 74 252 | 740 264 | 100 425 | ol | 224 120 | FO 00 |
| 50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM | 74, 353 2, 360 | 740, 364 23, 500 | 108, 425 1, 269 | 0 | 226, 130 0 | 50. 00 52. 00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 36, 449 | 23, 300 | 23, 199 | 0 | 205, 227 | 54.00 |
| 57. 00 05700 CT SCAN | 3, 303 | o | 14, 212 | o | 79, 811 | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 2, 487 | О | 2, 719 | 0 | 15, 202 | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | 0 | 0 | 0 | 59. 00 |
| 60. 00 06000 LABORATORY | 48, 464 | 0 | 285, 130 | 0 | 218, 529 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0 | 0 | 0 | 0 | 12 ((0 | 60.01 |
| 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY | 16, 141 37, 332 | 0 | 5, 333 5, 736 | 0 | 12, 668 8, 234 | 65. 00 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 3, 898 | 0 | 3, 730 17 | 0 | 1, 267 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 1, 194 | ő | 2 | Ö | 633 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 3, 360 | О | 8, 687 | 0 | 11, 402 | 69. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 493, 635 | 0 | 26, 604 | 71. 00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | 824, 332 | 0 | 54, 474 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 5, 676, 723 | 1 000 | 73.00 |
| 76. 00 03950 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS | 3, 855 | 38, 387 | 820 | 0 | 1, 900 | 76. 00 |
| 88. 00 08800 RURAL HEALTH CLINIC | O | 813, 646 | 7, 735 | 0 | 7, 601 | 88. 00 |
| 88.01 08801 RURAL HEALTH CLINIC II | 0 | 1, 355, 030 | 9, 560 | 0 | 29, 771 | 88. 01 |
| 88.02 08802 RURAL HEALTH CLINIC III | O | 139, 616 | 2, 647 | 0 | 0 | 88. 02 |
| 91. 00 09100 EMERGENCY | 47, 532 | 473, 292 | 49, 325 | 0 | 235, 629 | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY | O | O | 3, 591 | O | 2 167 | 101. 00 |
| SPECIAL PURPOSE COST CENTERS | <u> </u> | U U | 3, 391 | U _I | 3, 107 | 101.00 |
| 113. 00 11300 NTEREST EXPENSE | | | | | | 113. 00 |
| 114.00 11400 UTILIZATION REVIEW-SNF | | | | | | 114.00 |
| 116. 00 11600 HOSPI CE | 0 | 0 | 2, 083 | 0 | | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 470, 956 | 4, 829, 943 | 1, 916, 992 | 5, 676, 723 | 1, 380, 215 | 118. 00 |
| NONREI MBURSABLE COST CENTERS | ٥ | ٥ | 0 | 0 | 0 | 100.00 |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 0 | 0 | 0 | | 190. 00 192. 00 |
| 194. 00 07950 HOSPI TALI ST | 0 | 0 | 0 | 0 | | 194. 00 |
| 194. 01 07951 RENTAL | 0 | O | 0 | o | | 194. 01 |
| 194.05 07955 OTHER NONREIMBURSABLE COSTS | 0 | 0 | 0 | 0 | 0 | 194. 05 |
| 194.06 07956 DR AFZAL | 0 | 0 | 0 | 0 | | 194. 06 |
| 194. 07 07957 PHI LLI PS HALL | 0 | 0 | 0 | 0 | | 194. 07 |
| 194. 08 07958 OB DRS | 0 | 0 | 0 | 0 | | 194. 08 194. 09 |
| 194. 09 07959 THE WATERS 194. 10 07960 CAMBRI DGE CLTY | | ٥ | 0 | 0 | | 194. 09 |
| 194. 11 07961 WELL BEING | | n | 0 | 0 | | 194. 10 |
| 194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC | ol | o | Ö | o | | 194. 12 |
| 194. 13 07963 NEW CASTLE PEDIATRICS | o | o | 0 | 0 | 0 | 194. 13 |
| 194. 14 07964 HENRY COUNTY RADI OLOGY | 0 | 0 | 0 | 0 | | 194. 14 |
| 194. 15 07965 HENRY COUNTY ANESTHESI OLOGY | 0 | 0 | 0 | o | | 194. 15 |
| 194.16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY | 0 | 0 | 0 | 0 | 0 | 194. 16 |
| 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers | ام | n | 0 | ٥ | n | 200. 00 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 470, 956 | 4, 829, 943 | 1, 916, 992 | 5, 676, 723 | 1, 380, 215 | |
| | | | | , ., | | |

| Peri od: | Worksheet B | From 01/01/2021 | Part | | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0030

| | | | | Ť | o 12/31/2021 Date/Time Pro 5/26/2022 3: | |
|--------------------|---|------------------------------|-------------------------|---------------|---|--------------------|
| | Cost Center Description | Subtotal | Intern & | Total | 372072022 3. | 45 pili |
| | | | Resi dents | | | |
| | | | Cost & Post | | | |
| | | | Stepdown Adjustments | | | |
| | | 24. 00 | 25. 00 | 26.00 | | |
| | GENERAL SERVICE COST CENTERS | | | Г | | |
| 1. 00 2. 00 | 00100 NEW CAP REL COSTS-BLDG & FLXT 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | 1.00 2.00 |
| 4. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | 4.00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | | | | | 5.00 |
| 7.00 | 00700 OPERATION OF PLANT | | | | | 7.00 |
| 8. 00 9. 00 | 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG | | | | | 8. 00 9. 00 |
| 10. 00 | 01000 DI ETARY | | | | | 10.00 |
| 11. 00 | 01100 CAFETERI A | | | | | 11.00 |
| | 01300 NURSING ADMINISTRATION | | | | | 13.00 |
| | 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY | | | | | 14.00 |
| | 01600 MEDICAL RECORDS & LIBRARY | | | | | 15. 00 16. 00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 14, 074, 371 | 0 | | | 30.00 |
| | 03100 I NTENSI VE CARE UNI T | 5, 300, 351 | 0 | | | 31.00 |
| 43. 00 | 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS | 1, 352, 332 | 0 | 1, 352, 332 | | 43.00 |
| 50.00 | 05000 OPERATING ROOM | 9, 746, 505 | 0 | 9, 746, 505 | | 50.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 448, 539 | | | | 52.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 5, 072, 137 | 0 | | | 54.00 |
| 57. 00 58. 00 | 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) | 855, 881 526, 047 | 0 | | | 57. 00 58. 00 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0 320,047 | 0 | | | 59.00 |
| 60.00 | 06000 LABORATORY | 8, 767, 374 | 0 | 8, 767, 374 | | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | 0 | | | 60. 01 |
| 65. 00 66. 00 | 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY | 2, 248, 922 3, 389, 525 | 0 | | | 65. 00 66. 00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 3, 384, 323 | 0 | | | 67.00 |
| | 06800 SPEECH PATHOLOGY | 156, 170 | 0 | 1 | | 68.00 |
| | 06900 ELECTROCARDI OLOGY | 590, 056 | 0 | 590, 056 | | 69.00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT | 2, 173, 840 10, 735, 080 | 0 | | | 71. 00 72. 00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 5, 676, 723 | 0 | | | 73.00 |
| | 03950 CARDI AC REHAB | 378, 564 | 0 | | | 76.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | |
| | 08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II | 9, 574, 439 16, 875, 071 | 0 | | | 88. 00 88. 01 |
| | 08802 RURAL HEALTH CLINIC III | 1, 864, 715 | _ | | | 88. 02 |
| 91. 00 | 09100 EMERGENCY | 8, 764, 256 | 0 | | | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0 | | | 92.00 |
| 101 00 | OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY | 2, 285, 557 | 0 | 2, 285, 557 | | 101.00 |
| 101.00 | SPECIAL PURPOSE COST CENTERS | 2, 265, 557 | 0 | 2, 200, 007 | | 1101.00 |
| | 11300 I NTEREST EXPENSE | | | | | 113. 00 |
| | 11400 UTILIZATION REVIEW-SNF | | _ | | | 114.00 |
| 116. 00 118. 00 | 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) | 1, 130, 313 112, 386, 454 | 0 | | | 116. 00 118. 00 |
| 110.00 | NONREI MBURSABLE COST CENTERS | 112, 360, 434 | 0 | 112, 300, 434 | | 1110.00 |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 50, 556 | 0 | 50, 556 | | 190. 00 |
| | 19200 PHYSICIANS' PRIVATE OFFICES | 3, 036, 311 | 0 | | | 192.00 |
| | 07950 H0SPI TALI ST 07951 RENTAL | 127 251 | 0 | | | 194. 00 194. 01 |
| | 07955 OTHER NONREIMBURSABLE COSTS | 127, 251 257, 405 | 0 | | | 194.01 |
| | 07956 DR AFZAL | 8, 501 | 0 | 1 | | 194.06 |
| | 07957 PHILLIPS HALL | 5, 905 | 0 | | | 194. 07 |
| | 07958 0B DRS | 9, 758 | 0 | | | 194. 08 |
| | 07959 THE WATERS 07960 CAMBRIDGE CITY | 1, 315, 360 0 | 0 | | | 194. 09 194. 10 |
| 194. 11 | 07961 WELL BEING | 554 | 0 | | | 194. 11 |
| | 07962 ACTIVATE HEALTH EMPLOYER CLINIC | 77, 318 | 0 | | | 194. 12 |
| | 07963 NEW CASTLE PEDIATRICS | 0 | 0 | | | 194. 13 194. 14 |
| | 07964 HENRY COUNTY RADIOLOGY 07965 HENRY COUNTY ANESTHESIOLOGY | 2, 288, 386 0 | 0 | | | 194. 14 |
| | 07966 NEW CASTLE IMMEDICATE CARE & FAMILY | 0 | 0 | | | 194. 16 |
| 200.00 | Cross Foot Adjustments | 0 | 0 | | | 200. 00 |
| 201.00 | | 110 543 753 | 0 | | | 201.00 |
| 202. 00 | TOTAL (sum lines 118 through 201) | 119, 563, 759 | 0 | 119, 563, 759 | I | 202.00 |
| | | | | | | |

| 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: 15-0030

| | | | Ť | o 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
|---|---------------------------|-------------------------|--------------------|-------------------------|-----------------------------|--------------------|
| | | CAPI TAL REI | LATED COSTS | | 372072022 3.4 | 5 piii |
| Cost Center Description | Directly | NEW BLDG & | NEW MVBLE | Subtotal | EMPLOYEE | |
| | Assigned New | FLXT | EQUI P | | BENEFI TS | |
| | Capi tal Related Costs | | | | DEPARTMENT | |
| | 0 | 1.00 | 2.00 | 2A | 4. 00 | |
| GENERAL SERVICE COST CENTERS 1.00 OO100 NEW CAP REL COSTS-BLDG & FLXT | | | Ι | | | 1.00 |
| 2. 00 OO200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT | 0 | 34, 124 | | | 36, 372 | 4.00 |
| 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT | 0 | 730, 581 1, 345, 777 | 48, 126 88, 652 | 778, 707 1, 434, 429 | 4, 395 971 | 5. 00 7. 00 |
| 8.00 00800 LAUNDRY & LINEN SERVICE | 0 | 67, 246 | 4, 430 | 71, 676 | 0 | 8. 00 |
| 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY | 0 | 39, 058 141, 882 | | | 0 227 | 9. 00 10. 00 |
| 11. 00 01100 CAFETERI A | O | 38, 763 | | | 191 | 11.00 |
| 13. 00 01300 NURSING ADMINISTRATION | 0 | 80, 946 | | | 1, 687 | 13.00 |
| 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY | 0 | 140, 604 30, 704 | | 149, 866 32, 727 | 380 | 14. 00 15. 00 |
| 16. 00 01600 MEDICAL RECORDS & LIBRARY | 0 | 20, 522 | 1, 352 | 21, 874 | 470 | 16. 00 |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | 572, 659 | 37, 723 | 610, 382 | 3, 942 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | O | 228, 038 | 15, 022 | 243, 060 | | 31.00 |
| 43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS | 0 | 60, 307 | 3, 973 | 64, 280 | 396 | 43.00 |
| 50. 00 05000 OPERATING ROOM | 0 | 420, 084 | 27, 672 | 447, 756 | 3, 787 | 50.00 |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 30, 645 | | | 125 | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN | 0 | 222, 553 8, 610 | | 237, 213 9, 177 | 1, 364 139 | 54. 00 57. 00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | Ö | 10, 516 | | 11, 209 | 100 | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY | 0 | 142 204 | 0 10, 697 | 172 091 | 1 440 | 59. 00 60. 00 |
| 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY | 0 | 162, 384 0 | 10, 697 | 173, 081 0 | 1, 440 0 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 48, 552 | | | 587 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY | 0 | 21, 092 3, 420 | | 22, 481 3, 645 | 892 152 | 66. 00 67. 00 |
| 68. 00 06800 SPEECH PATHOLOGY | Ö | 3, 794 | 250 | 4, 044 | 57 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 0 | 0 | 0 | 0 | 137 0 | 69. 00 71. 00 |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | 0 | 0 | 0 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 73.00 |
| 76. 00 03950 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS | 0 | 13, 976 | 921 | 14, 897 | 112 | 76. 00 |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | 1 | 0 | 3, 025 | 88. 00 |
| 88. 01 08801 RURAL HEALTH CLINIC II 88. 02 08802 RURAL HEALTH CLINIC III | 0 | 0 | 0 | 0 | 5, 677 528 | 88. 01 88. 02 |
| 91. 00 09100 EMERGENCY | Ö | 207, 732 | 13, 684 | 221, 416 | 1, 944 | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | | | | 0 | | 92.00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | 764 | 101.00 |
| SPECIAL PURPOSE COST CENTERS | | | I | | | |
| 113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF | | | | | | 113. 00 114. 00 |
| 116. 00 11600 HOSPI CE | 0 | 0 | О | 0 | | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS | 0 | 4, 684, 569 | 308, 590 | 4, 993, 159 | 35, 061 | 118. 00 |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 17, 023 | 1, 121 | 18, 144 | 0 | 190. 00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 0 | 0 | 0 | | 192.00 |
| 194. 00 07950 HOSPI TALI ST 194. 01 07951 RENTAL | 0 | 0 | 18, 926 | 18, 926 | | 194. 00 194. 01 |
| 194.05 07955 OTHER NONREIMBURSABLE COSTS | 0 | 0 | 0 | 0 | 0 | 194. 05 |
| 194. 06 07956 DR AFZAL 194. 07 07957 PHI LLI PS HALL | 0 | 0 | 0 | 0 | | 194. 06 194. 07 |
| 194. 08 07958 OB DRS | o | 0 | ő | 0 | | 194. 08 |
| 194. 09 07959 THE WATERS | 0 | 482, 238 | 31, 767 | 514, 005 | | 194.09 |
| 194. 10 07960 CAMBRI DGE CI TY 194. 11 07961 WELL BEI NG | 0 | 0 | | 0 | | 194. 10 194. 11 |
| 194.12 07962 ACTIVATE HEALTH EMPLOYER CLINIC | 0 | 0 | 0 | 0 | 0 | 194. 12 |
| 194. 13 07963 NEW CASTLE PEDIATRICS 194. 14 07964 HENRY COUNTY RADIOLOGY | 0 | 0 | 0 | 0 | | 194. 13 194. 14 |
| 194. 15 07965 HENRY COUNTY ANESTHESI OLOGY | 0 | Ö | 0 | 0 | 0 | 194. 15 |
| 194.16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY 200.00 Cross Foot Adjustments | 0 | 0 | 0 | 0 | | 194. 16 200. 00 |
| 201.00 Negative Cost Centers | | 0 | 0 | 0 | 0 | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 0 | 5, 183, 830 | 360, 404 | 5, 544, 234 | 36, 372 | 202.00 |
| | | | | | | |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0030

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 3:43 pm

| | | | | | 5/26/2022 3: 4 | 3 pm |
|---|------------------|--------------|---------------|---------------|----------------|---------|
| Cost Center Description | ADMI NI STRATI V | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | |
| | E & GENERAL | PLANT | LINEN SERVICE | | | |
| | 5. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5. 00 00500 ADMINISTRATIVE & GENERAL | 783, 102 | | | | | 5.00 |
| 7. 00 00700 OPERATION OF PLANT | 40, 659 | 1, 476, 059 | , | | | 7. 00 |
| 8. 00 00800 LAUNDRY & LINEN SERVICE | 4, 142 | 22, 551 | | | | 8.00 |
| 9. 00 00900 HOUSEKEEPI NG | 7, 922 | 13, 098 | | 66, 825 | | 9. 00 |
| 10. 00 01000 DI ETARY | 6, 126 | | | 2, 207 | 208, 490 | 10.00 |
| 11. 00 01100 CAFETERI A | | 12, 999 | | | 200, 490 | 11.00 |
| | 2, 650 | | | 603 | | |
| | 30, 503 | 27, 146 | | 1, 259 | 0 | 13.00 |
| 14. 00 01400 CENTRAL SERVICES & SUPPLY | 10, 909 | 47, 152 | | 2, 188 | 0 | 14.00 |
| 15. 00 01500 PHARMACY | 36, 815 | | 1 | 478 | 0 | 15.00 |
| 16. 00 01600 MEDICAL RECORDS & LIBRARY | 8, 674 | 6, 882 | 0 | 319 | 0 | 16. 00 |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 71, 233 | 192, 043 | 19, 908 | 8, 909 | 163, 190 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 27, 565 | 76, 473 | 4, 477 | 3, 548 | 45, 300 | 31.00 |
| 43. 00 04300 NURSERY | 7, 297 | 20, 224 | 1, 457 | 938 | 0 | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50. 00 05000 OPERATING ROOM | 50, 742 | 140, 876 | 17, 686 | 6, 536 | 0 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 2, 394 | 10, 277 | 459 | 477 | 0 | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 28, 644 | 74, 634 | | | 0 | 54.00 |
| 57. 00 05700 CT SCAN | 4, 872 | 2, 887 | | 134 | 0 | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 3, 194 | 3, 527 | | 164 | 0 | 58.00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0, 1,71 | 0,027 | | 0 | 0 | 59.00 |
| 60. 00 06000 LABORATORY | 51, 980 | 54, 456 | · - | 2, 526 | 0 | 60.00 |
| | 1 | | 1 | | | |
| 60. 01 06001 BLOOD LABORATORY | 0 | 0 | _ | 0 | 0 | 60. 01 |
| 65. 00 06500 RESPIRATORY THERAPY | 13, 787 | 21, 490 | | 997 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 16, 003 | 172, 616 | | 8, 008 | 0 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 2, 530 | 1, 147 | 326 | 53 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 968 | 1, 272 | 2 | 59 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 3, 711 | 0 | 0 | 0 | 0 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 10, 830 | 0 | 0 | 0 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 64, 555 | 0 | o | 0 | 0 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0.7000 | 0 | o o | 0 | 0 | 73.00 |
| 76. 00 03950 CARDI AC REHAB | 2, 028 | 4, 687 | | 217 | 0 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | 2,020 | 4,007 | | 217 | 0 | 70.00 |
| 88. 00 08800 RURAL HEALTH CLINIC | 53, 775 | 103, 928 | 612 | 4, 822 | 0 | 88. 00 |
| 88. 01 08801 RURAL HEALTH CLINIC II | 92, 400 | 268, 639 | | 12, 464 | 0 | 88. 01 |
| | | | 1 | | 0 | |
| | 10, 157 | 33, 619 | | 1, 560 | | 88. 02 |
| 91. 00 09100 EMERGENCY | 48, 943 | 69, 664 | 17, 621 | 3, 232 | 0 | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101.00 10100 HOME HEALTH AGENCY | 14, 421 | 15, 096 | 0 | 700 | 0 | 101. 00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 113.00 11300 I NTEREST EXPENSE | | | | | | 113. 00 |
| 114.00 11400 UTILIZATION REVIEW-SNF | | | | | | 114. 00 |
| 116. 00 11600 HOSPI CE | 6, 877 | 15, 089 | 0 | 700 | 0 | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 737, 306 | 1, 470, 350 | 77, 258 | 66, 560 | 208, 490 | 118.00 |
| NONREI MBURSABLE COST CENTERS | | | | | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 140 | 5, 709 | 0 | 265 | 0 | 190. 00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 19, 887 | 0 | 0 | | | 192.00 |
| 194. 00 07950 H0SPI TALI ST | 0 | 0 | o o | 0 | | 194. 00 |
| 194. 01 07951 RENTAL | 833 | 0 | o o | 0 | | 194. 01 |
| | 1, 597 | 0 | _ | 0 | | 194. 05 |
| 194. 05 07955 OTHER NONREI MBURSABLE COSTS | | 0 | 1, 837 | 0 | | |
| 194. 06 07956 DR AFZAL | 56 | 0 | 700 | 0 | | 194.06 |
| 194. 07 07957 PHI LLI PS HALL | 0 | 0 | 799 | 0 | | 194. 07 |
| 194. 08 07958 OB DRS | 0 | 0 | 1, 320 | 0 | | 194. 08 |
| 194.09 07959 THE WATERS | 7, 785 | 0 | 17, 155 | 0 | | 194. 09 |
| 194. 10 07960 CAMBRI DGE CITY | 0 | 0 | 0 | 0 | 0 | 194. 10 |
| 194. 11 07961 WELL BEING | 4 | 0 | 0 | o | 0 | 194. 11 |
| 194.12 07962 ACTIVATE HEALTH EMPLOYER CLINIC | 506 | 0 | 0 | ol | 0 | 194. 12 |
| 194. 13 07963 NEW CASTLE PEDIATRICS | 0 | o o | 0 | ol | | 194. 13 |
| 194. 14 07964 HENRY COUNTY RADIOLOGY | 14, 988 | l n | ا ا | n | | 194. 14 |
| 194. 15 07965 HENRY COUNTY ANESTHESI OLOGY | , , , so | ١ | م م | 0 | | 194. 15 |
| 194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY | 0 | | | 0 | | 194. 15 |
| | | | Ί | ۷ | | |
| 200.00 Cross Foot Adjustments | _ | _ | , | _ ا | | 200.00 |
| 201.00 Negative Cost Centers | 700 400 | 1 47/ 050 | 00000 | ,, 00 | | 201.00 |
| 202.00 TOTAL (sum lines 118 through 201) | 783, 102 | 1, 476, 059 | 98, 369 | 66, 825 | 208, 490 | 202.00 |
| | | | | | | |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0030

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2021 Part II
To 12/31/2021 Date/Time Prepared: 5/26/2022 3:43 pm

| | | 045575014 | NUIDOL NO | 05117011 | | 5/26/2022 3: 4 | |
|---|--|--|--|--|---|---|---|
| | Cost Center Description | CAFETERI A | NURSI NG ADMI NI STRATI O N | CENTRAL SERVICES & SUPPLY | PHARMACY | MEDI CAL RECORDS & LI BRARY | |
| | JOSUS DE LOS CONTROLOS DE LA C | 11. 00 | 13. 00 | 14. 00 | 15. 00 | 16. 00 | |
| 1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 | GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY | | | | | | 1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 |
| 11. 00 13. 00 14. 00 15. 00 16. 00 | 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 57, 759 4, 184 1, 303 0 2, 495 | 151, 057 0 0 0 | 211, 798 351 44 | 80, 668 0 | 40, 758 | 11. 00 13. 00 14. 00 15. 00 16. 00 |
| 30. 00 31. 00 43. 00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT | 10, 774 3, 656 919 | 27, 354 9, 284 | 4, 822 1, 910 | 0 | 4, 022 1, 964 | 31.00 |
| 43.00 | 04300 NURSERY ANCILLARY SERVICE COST CENTERS | 919 | 2, 334 | 445 | 0 | 1, 122 | 43.00 |
| 50. 00 52. 00 54. 00 57. 00 58. 00 59. 00 | | 9, 119 289 4, 470 405 305 0 | 23, 155 735 0 0 0 | 11, 979 140 2, 563 1, 570 300 | 0 0 0 0 | 6, 678 0 6, 060 2, 357 449 0 | 52.00 54.00 57.00 58.00 |
| 60. 00 60. 01 65. 00 66. 00 67. 00 68. 00 | 06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY | 5, 944 5, 940 1, 980 4, 578 478 146 | 0 0 0 0 | - | 0 0 0 | 6, 453 0 374 243 37 19 | 60. 00 60. 01 65. 00 66. 00 67. 00 |
| 69. 00 71. 00 72. 00 73. 00 76. 00 | 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS | 412 0 0 0 473 | 0 0 0 0 1, 201 | 960 54, 540 91, 075 0 91 | 0 0 0 80, 668 0 | 337 786 1, 609 0 | 69.00 71.00 72.00 73.00 |
| 88. 00 88. 01 88. 02 91. 00 92. 00 | 08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III | 0 0 0 5, 829 | 25, 447 42, 378 4, 367 14, 802 | 855 1, 056 292 5, 450 | 0 0 0 0 | 224 879 0 6, 958 | 88. 01 88. 02 |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 0 | 397 | 0 | 94 | 101.00 |
| 114.00 | SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS | 0 57, 759 | 0 151, 057 | 230 211, 798 | 0 80, 668 | | 113. 00 114. 00 116. 00 118. 00 |
| 192. 00 194. 00 194. 00 194. 00 194. 00 194. 00 194. 00 194. 10 194. 11 194. 11 194. 11 194. 12 | 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES 0 07950 HOSPITALIST 0 07951 RENTAL 0 07956 DR AFZAL 7 07957 PHILLIPS HALL 8 07958 OB DRS 0 07950 CAMBRIDGE CITY 0 07961 WELL BEING 0 07962 ACTIVATE HEALTH EMPLOYER CLINIC 8 07963 NEW CASTLE PEDIATRICS 0 07964 HENRY COUNTY RADIOLOGY 0 07965 HENRY COUNTY ANESTHESIOLOGY 0 07966 NEW CASTLE IMMEDICATE CARE & FAMILY 0 Cross Foot Adjustments Negative Cost Centers | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 | 190. 00 192. 00 194. 00 194. 01 194. 05 194. 07 194. 08 194. 09 194. 10 194. 11 194. 12 194. 13 194. 14 194. 15 194. 16 200. 00 201. 00 |

| Period: | Worksheet B | From 01/01/2021 | Part II | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0030

| | | | | | To 12/31/2021 Part 11 To 12/31/2021 Date/Tim | e Prepared: 2 3:43 pm |
|---|----------------|---------------------|--------------------------|------------|---|--------------------------|
| Cost Center Descriptio | n | Subtotal | Intern & | Total | 37 207 202 | 2 3. 43 piii |
| | | | Residents Cost & Post | | | |
| | | | Stepdown | | | |
| | | 0.4.00 | Adjustments | 0/ 00 | | |
| GENERAL SERVICE COST CENTERS | <u> </u> | 24. 00 | 25. 00 | 26. 00 | | |
| 1. 00 00100 NEW CAP REL COSTS-BLDG | | | | | | 1.00 |
| 2. 00 00200 NEW CAP REL COSTS-MVBL | | | | | | 2.00 |
| 4. 00 00400 EMPLOYEE BENEFITS DEPA 5. 00 00500 ADMINISTRATIVE & GENER | 1 | | | | | 4. 00 5. 00 |
| 7. 00 00700 OPERATION OF PLANT | , AL | | | | | 7.00 |
| 8.00 00800 LAUNDRY & LINEN SERVIC | Ε | | | | | 8. 00 |
| 9. 00 00900 HOUSEKEEPI NG | | | | | | 9.00 |
| 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A | | | | | | 10.00 |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON | | | | • | | 13. 00 |
| 14.00 01400 CENTRAL SERVICES & SUP | PLY | | | | | 14.00 |
| 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BR | MDV | | | | | 15. 00 16. 00 |
| I NPATI ENT ROUTI NE SERVI CE CO | | | | | | 10.00 |
| 30. 00 03000 ADULTS & PEDIATRICS | | 1, 116, 579 | 0 | |) | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT 43.00 04300 NURSERY | | 418, 465 | 0 | 1 | | 31.00 |
| 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTE | FRS | 99, 412 | 0 | 99, 41 | <u> </u> | 43. 00 |
| 50. 00 05000 OPERATING ROOM | | 718, 314 | 0 | 718, 31 | 1 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR | ROOM | 47, 560 | 0 | | | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN | | 365, 568 | 0 | | | 54.00 |
| 57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE IMA | GING (MRI) | 21, 541 19, 248 | 0 | | | 57. 00 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI 0 | | 0 | 0 | 1 | | 59.00 |
| 60. 00 06000 LABORATORY | | 327, 507 | 0 | | | 60.00 |
| 60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY | | 01 554 | 0 | 1 | | 60. 01 65. 00 |
| 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY | | 91, 554 227, 295 | 0 | , | | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | 8, 370 | 0 | 1 | | 67. 00 |
| 68. 00 06800 SPEECH PATHOLOGY | | 6, 565 | 0 | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARG | ED TO DATIENTS | 5, 557 66, 156 | 0 | -, | | 69. 00 71. 00 |
| 72. 00 07100 MEDICAL 30FFETES CHARGE 72. 00 07200 I MPL. DEV. CHARGED TO | | 157, 239 | 0 | 1 | | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIE | | 80, 668 | 0 | 1 | | 73.00 |
| 76. 00 03950 CARDI AC REHAB | TEDC. | 23, 762 | 0 | 23, 76 | 2 | 76. 00 |
| 88. 00 08800 RURAL HEALTH CLINIC | EKS | 192, 688 | 0 | 192, 68 | 3 | 88. 00 |
| 88. 01 08801 RURAL HEALTH CLINIC II | | 423, 788 | 0 | | | 88. 01 |
| 88. 02 08802 RURAL HEALTH CLINIC II | I | 50, 523 | 0 | 1 | | 88. 02 |
| 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON- | DISTINCT DART) | 395, 859 | 0 | 1 | 7 | 91. 00 92. 00 |
| OTHER REIMBURSABLE COST CENT | | | | l . | | 92.00 |
| 101.00 10100 HOME HEALTH AGENCY | | 31, 472 | 0 | 31, 47 | 2 | 101. 00 |
| SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE | | | | | | 113. 00 |
| 114. 00 11400 UTI LI ZATI ON REVI EW-SNF | : | | | | | 114.00 |
| 116. 00 11600 HOSPI CE | | 23, 277 | 0 | 1 | | 116.00 |
| 118.00 SUBTOTALS (SUM OF LINE NONREIMBURSABLE COST CENTERS | | 4, 918, 967 | 0 | 4, 918, 96 | / | 118. 00 |
| 190. 00 19000 GIFT, FLOWER, COFFEE S | | 24, 258 | 0 | 24, 25 | 3 | 190. 00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OF | FICES | 20, 919 | 0 | 1 | | 192. 00 |
| 194. 00 07950 H0SPI TALI ST 194. 01 07951 RENTAL | | 0 19, 759 | 0 | | | 194. 00 194. 01 |
| 194. 05 07955 OTHER NONREI MBURSABLE | COSTS | 3, 434 | 0 | 3, 43 | | 194.01 |
| 194. 06 07956 DR AFZAL | | 56 | 0 | 1 | | 194. 06 |
| 194. 07 07957 PHI LLI PS HALL | | 799 | 0 | 799 | | 194. 07 |
| 194. 08 07958 0B_DRS 194. 09 07959 THE_WATERS | | 1, 320 539, 112 | 0 | ., | | 194. 08 194. 09 |
| 194.10 07960 CAMBRIDGE CITY | | 0 0 | 0 | 1 | | 194. 10 |
| 194. 11 07961 WELL BEING | | 4 | 0 | | 1 | 194. 11 |
| 194. 12 07962 ACTIVATE HEALTH EMPLOY | TER CLINIC | 506 0 | 0 | 500 | 5 | 194. 12 |
| 194. 13 07963 NEW CASTLE PEDIATRICS 194. 14 07964 HENRY COUNTY RADIOLOGY | , | 15, 100 | 0 | 15, 100 | ر ا (| 194. 13 194. 14 |
| 194. 15 07965 HENRY COUNTY ANESTHESI | | 13, 100 | 0 | 1 | | 194. 15 |
| 194. 16 07966 NEW CASTLE IMMEDICATE | | 0 | 0 | 1 | | 194. 16 |
| 200.00 Cross Foot Adjustments | | 0 | 0 | 1 | | 200.00 |
| 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 t | hrough 201) | 0 5, 544, 234 | 0 | 1 | 1 | 201. 00 202. 00 |
| | <u> </u> | , ., | | | • | 1 |

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0030 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 3:43 pm CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliatio ADMINISTRATIV **FOULP** BENEFITS E & GENERAL FI XT n (SQUARE (SQUARE DEPARTMENT (ACCUM. FEET) FEET) (GROSS COST) SALARI ES) 1. 00 2.00 4.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 263.718 1 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 278, 334 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 736 55, 839, 913 4.00 4.00 1.736 5.00 6, 751, 319 00500 ADMINISTRATIVE & GENERAL 5.00 37, 167 37, 167 -18, 257, 170 101, 306, 589 7.00 00700 OPERATION OF PLANT 68, 464 68, 464 1, 491, 861 5, 259, 874 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 3, 421 3, 421 0 535, 812 8.00 1, 987 1, 024, 779 00900 HOUSEKEEPI NG 1, 987 0 9.00 9 00 Ω 349, 183 0 10.00 01000 DI ETARY 7, 218 7, 218 792, 449 10.00 11.00 01100 CAFETERI A 1, 972 1, 972 292, 633 342, 813 11.00 01300 NURSING ADMINISTRATION 0 13.00 4, 118 4, 118 2, 591, 761 3, 946, 096 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14 00 7 153 7.153 583, 921 1, 411, 316 14 00 15.00 01500 PHARMACY 1,562 1,562 0 0 4, 762, 670 15.00 01600 MEDICAL RECORDS & LIBRARY 721, 252 1, 122, 113 16.00 1.044 1.044 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 9. 215, 137 30.00 03000 ADULTS & PEDIATRICS 29, 133 29, 133 6, 054, 823 0 30.00 31.00 03100 INTENSIVE CARE UNIT 11,601 11,601 1,885,886 0 3, 565, 966 31.00 43.00 04300 NURSERY 3,068 3,068 608, 690 944, 035 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 21, 371 21, 371 5, 817, 654 0 6, 564, 313 50.00 05200 DELIVERY ROOM & LABOR ROOM 1, 559 1, 559 191, 702 0 309, 735 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 322 11, 322 2, 095, 278 0 3, 705, 538 54.00 0 05700 CT SCAN 213, 836 630, 236 57 00 57 00 438 438 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 535 535 153, 260 413, 174 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 59.00 0 06000 LABORATORY 60.00 8, 261 8, 261 2, 211, 829 6, 724, 470 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 0 06500 RESPIRATORY THERAPY 2, 470 2, 470 901, 706 1, 783, 635 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 1,073 1,073 1, 369, 907 2,070,309 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 174 174 232, 791 327, 260 67.00 06800 SPEECH PATHOLOGY 68 00 193 193 87, 422 125, 270 68 00 0 06900 ELECTROCARDI OLOGY 209, 856 480, 087 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 1, 401, 099 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 8, 351, 239 0 72.00 72.00C 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 r 0 Λ 73.00 76.00 03950 CARDI AC REHAB 711 711 172, 391 262, 389 76.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 88 00 0 4, 647, 464 0 6, 956, 672 88.01 08801 RURAL HEALTH CLINIC II 0 C 8, 691, 617 0 11, 952, 992 88.01 88.02 08802 RURAL HEALTH CLINIC III 810, 435 0 1, 314, 020 88.02 09100 EMERGENCY 10, 568 10, 568 0 91.00 2, 985, 961 6, 331, 527 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 1, 172, 987 0 1, 865, 535 101. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 528, 508 889, 611 116, 00 0 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 238, 319 238, 319 53, 825, 933 -18, 257, 170 95, 382, 171 118. 00 NONREIMBURSABLE COST CENTERS 18, 144 190. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 866 866 1, 584, 664 2, 572, 672 192. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 C 194. 00 07950 HOSPI TALI ST 0 0 0 0 194.00 194. 01 07951 RENTAL 0 0 0 107, 820 194. 01 14.616 194. 05 07955 OTHER NONREI MBURSABLE COSTS 0 0 0 206, 593 194. 05 C o 194.06 07956 DR AFZAL 0 7, 203 194.06 0 0 194. 07 07957 PHILLIPS HALL 0 0 0 0 194.07 194. 08 07958 OB DRS 0 0 194.08 0 0 194. 09 07959 THE WATERS 24.533 24.533 257.093 1, 007, 051 194. 09 194. 10 07960 CAMBRIDGE CITY 0 194. 10 0 194. 11 07961 WELL BEING 0 0 0 469 194. 11 194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC 0 0 65, 512 194. 12 0 0 194. 13 07963 NEW CASTLE PEDIATRICS 0 0 194. 13 0 0 194. 14 07964 HENRY COUNTY RADIOLOGY 0 0 172, 223 1, 938, 954 194. 14 194. 15 07965 HENRY COUNTY ANESTHESI OLOGY 0 194. 15 194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY 0 0 194. 16 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 201.00

| Heal th Fin | ancial Systems HE | NRY COUNTY MEMO | ORIAL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|-------------|--|------------------|--------------------|----------------------|--------------------------------|------------------------------|---------|
| COST ALLOC | CATION - STATISTICAL BASIS | | Provi der CO | | eri od: | Worksheet B-1 | |
| | | | | | rom 01/01/2021 o 12/31/2021 | | |
| | | CAPITAL REL | ATED COSTS | | | | |
| | Cost Center Description | NEW BLDG & | NEW MVBLE EQUIP | EMPLOYEE BENEFITS | Reconciliatio | ADMINISTRATIV E & GENERAL | |
| | | (SQUARE FEET) | (SQUARE FEET) | DEPARTMENT (GROSS | | (ACCUM. | |
| | | , | . ==., | SALARI ES) | | | |
| | | 1. 00 | 2. 00 | 4.00 | 5A | 5. 00 | |
| 202. 00 | Cost to be allocated (per Wkst. B, Part I) | 5, 183, 830 | 360, 404 | 17, 698, 591 | | 18, 257, 170 | 202. 00 |
| 203. 00 | Unit cost multiplier (Wkst. B, Part I) | 19. 656717 | 1. 294862 | 0. 316952 | 2 | 0. 180217 | 203.00 |
| 204. 00 | Cost to be allocated (per Wkst. B, Part II) | | | 36, 372 | 2 | 783, 102 | 204. 00 |
| 205. 00 | Unit cost multiplier (Wkst. B, Part | | | 0. 000651 | | 0. 007730 | 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 Center Description | | Provi der C | | eriod: rom 01/01/2021 o 12/31/2021 | Worksheet B-1 Date/Time Pre | |
|--|---|---|---|---|--|--|--|
| locate. | Cost Center Description | | | | | 5/26/2022 3: 4 | |
| CENE | | OPERATION OF PLANT (SQUARE FEET) | LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) | HOUSEKEEPI NG (SQUARE FEET) | DI ETARY (PATI ENT DAYS) | CAFETERIA (FTE'S) | 5 piii |
| CENE | | 7. 00 | 8.00 | 9. 00 | 10.00 | 11. 00 | |
| 1. 00 0010 2. 00 0020 4. 00 0050 7. 00 0070 8. 00 0080 9. 00 0090 10. 00 0100 11. 00 0110 13. 00 0130 14. 00 0140 15. 00 0150 | RAL SERVICE COST CENTERS O NEW CAP REL COSTS-BLDG & FIXT O NEW CAP REL COSTS-BLDG & FIXT O NEW CAP REL COSTS-MYBLE EQUIP O EMPLOYEE BENEFITS DEPARTMENT O ADMI NI STRATI VE & GENERAL O OPERATION OF PLANT O LAUNDRY & LINEN SERVICE O HOUSEKEEPING O DI ETARY O CAFETERIA O NURSING ADMINISTRATION O CENTRAL SERVICES & SUPPLY O PHARMACY | 223, 919 3, 421 1, 987 7, 218 1, 972 4, 118 7, 153 1, 562 | 705, 361 29, 931 8, 039 0 0 0 | 218, 511 7, 218 1, 972 4, 118 7, 153 1, 562 | 9, 343 0 0 0 0 | 662, 129 47, 963 14, 935 0 | 13. 00 14. 00 15. 00 |
| | O MEDICAL RECORDS & LIBRARY | 1, 044 | . 0 | 1, 044 | 0 | 28, 604 | 16.00 |
| 30. 00 0300 31. 00 0310 43. 00 0430 | TIENT ROUTINE SERVICE COST CENTERS O ADULTS & PEDIATRICS O INTENSIVE CARE UNIT O NURSERY LLARY SERVICE COST CENTERS | 29, 133 11, 601 3, 068 | 32, 100 | 11, 601 | 2, 030 | 123, 493 41, 914 10, 536 | 31.00 |
| 50. 00 0500 52. 00 0520 54. 00 0540 57. 00 0570 58. 00 0580 59. 00 0590 60. 00 0600 | O OPERATING ROOM O DELIVERY ROOM & LABOR ROOM O RADIOLOGY-DIAGNOSTIC O CT SCAN O MAGNETIC RESONANCE IMAGING (MRI) O CARDIAC CATHETERIZATION O LABORATORY 1 BLOOD LABORATORY | 21, 371 1, 559 11, 322 438 535 0 8, 261 | 3, 290 51, 328 0 0 0 0 892 | 1, 559 11, 322 438 535 0 8, 261 | 0 0 0 | 104, 535 3, 318 51, 245 4, 644 3, 497 0 68, 137 0 | 52. 00 54. 00 57. 00 58. 00 59. 00 60. 00 |
| 66. 00 0660 67. 00 0670 68. 00 0680 69. 00 0710 72. 00 0720 73. 00 0730 76. 00 0395 | O RESPIRATORY THERAPY O PHYSICAL THERAPY O OCCUPATIONAL THERAPY O SPEECH PATHOLOGY O ELECTROCARDIOLOGY O MEDICAL SUPPLIES CHARGED TO PATIENTS O IMPL. DEV. CHARGED TO PATIENT O DRUGS CHARGED TO PATIENTS O CARDIAC REHAB ATIENT SERVICE COST CENTERS | 3, 260 26, 186 174 193 0 0 0 0 | 13, 196 2, 338 0 0 0 0 0 | 26, 186 174 | 0 0 0 0 0 0 | 5, 480 1, 679 4, 724 0 0 0 | 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 |
| 88. 00 0880 88. 01 0880 91. 00 0910 92. 00 0920 | O RURAL HEALTH CLINIC 1 RURAL HEALTH CLINIC II 2 RURAL HEALTH CLINIC III 0 EMERGENCY 0 OBSERVATION BEDS (NON-DISTINCT PART) | 15, 766 40, 753 5, 100 10, 568 | 2, 114 0 | 40, 753 5, 100 | 0 | 0 0 0 66, 826 | 88. 01 88. 02 |
| | R REIMBURSABLE COST CENTERS O HOME HEALTH AGENCY | 2, 290 | 0 | 2, 290 | 0 | 0 | 101. 00 |
| 113. 00 1130 114. 00 1140 116. 00 1160 118. 00 | SUBTOTALS (SUM OF LINES 1 through 117) | 2, 289 | 0 | 2, 289 | 0 | | 113. 00 114. 00 116. 00 118. 00 |
| 190. 00 1900 192. 00 1920 194. 00 0795 194. 05 0795 194. 05 0795 194. 06 0795 194. 08 0795 194. 10 0796 194. 11 0796 194. 12 0796 194. 13 0796 194. 14 0796 194. 15 0796 194. 16 0796 200. 00 201. 00 | 5 OTHER NONREIMBURSABLE COSTS 6 DR AFZAL 7 PHILLIPS HALL 8 OB DRS 9 THE WATERS 0 CAMBRIDGE CITY 1 WELL BEING 2 ACTIVATE HEALTH EMPLOYER CLINIC 3 NEW CASTLE PEDIATRICS 4 HENRY COUNTY RADIOLOGY 5 HENRY COUNTY ANESTHESIOLOGY 6 NEW CASTLE IMMEDICATE CARE & FAMILY Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) | 866 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 13, 172 0 5, 728 9, 465 123, 010 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | |
| 203. 00 | Unit cost multiplier (Wkst. B, Part I) | 27. 723387 | 1. 030984 | 5. 928333 | 126. 987905 | 0. 711275 | 203. 00 |

| Health Financial Systems | HENRY COUNTY MEN | MORIAL HOSPITAL | - | In Lie | u of Form CMS-2 | 2552-10 |
|---|------------------|-----------------|---------------|-----------------------------|--------------------------------|---------|
| COST ALLOCATION - STATISTICAL BASIS | | Provi der Co | | Peri od: From 01/01/2021 | Worksheet B-1 | |
| | | | | To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
| Cost Center Description | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | CAFETERI A | |
| | PLANT | LINEN SERVICE | (SQUARE | (PATI ENT | (FTE' S) | |
| | (SQUARE | (POUNDS OF | FEET) | DAYS) | | |
| | FEET) | LAUNDRY) | | | | |
| | 7. 00 | 8. 00 | 9. 00 | 10.00 | 11. 00 | |
| 204.00 Cost to be allocated (per Wkst. B, | 1, 476, 059 | 98, 369 | 66, 82 | 5 208, 490 | 57, 759 | 204.00 |
| Part II) | | | | | | |
| 205.00 Unit cost multiplier (Wkst. B, Part | 6. 591933 | 0. 139459 | 0. 30582 | 0 22. 315102 | 0. 087232 | 205.00 |
| | | | | | | |
| 206.00 NAHE adjustment amount to be allocat | ed | | | | | 206.00 |
| (per Wkst. B-2) | | | | | | |
| 207.00 NAHE unit cost multiplier (Wkst. D, | | | | | | 207.00 |
| Parts III and IV) | | | | | | |
| · · · · | | | | • | • | • |

| | | ENRY COUNTY MEMO | | | | u of Form CMS-2552-10 |
|--------------------|--|----------------------|---------------------|-----------------|--------------------------|---------------------------------------|
| COST A | LOCATION - STATISTICAL BASIS | | Provi der CC | | eriod: rom 01/01/2021 | Worksheet B-1 |
| | | | | To | | Date/Time Prepared: 5/26/2022 3:43 pm |
| | Cost Center Description | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | 372072022 3.43 piii |
| | | ADMI NI STRATI O | SERVICES & | (COSTED | RECORDS & | |
| | | N (DI RECT | SUPPLY (COSTED | REQUIS.) | LI BRARY (TI ME | |
| | | NRSI NG HRS) | REQUIS.) | | SPENT) | |
| | CENEDAL CEDVICE COCT CENTEDS | 13. 00 | 14. 00 | 15. 00 | 16. 00 | |
| 1. 00 | GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FLXT | | | | | 1.00 |
| 2. 00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | 4.00 |
| 5. 00 7. 00 | 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT | | | | | 5. 00 7. 00 |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | | | | | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG | | | | | 9.00 |
| 10. 00 11. 00 | 01000 DI ETARY 01100 CAFETERI A | | | | | 10.00 11.00 |
| | 01300 NURSING ADMINISTRATION | 681, 959 | | | | 13.00 |
| | 01400 CENTRAL SERVICES & SUPPLY | 0 | 14, 182, 541 | 100 | | 14.00 |
| | 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY | 0 | 23, 492 2, 968 | | 2, 179 | 15. 00 16. 00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | - | =, | - | _, | |
| | 03000 ADULTS & PEDIATRICS | 123, 493 | 322, 860 | 0 | 215 | |
| | 03100 INTENSIVE CARE UNIT 04300 NURSERY | 41, 914 10, 536 | 127, 899 29, 820 | | 105 60 | |
| 10.00 | ANCILLARY SERVICE COST CENTERS | 10,000 | 27,020 | <u> </u> | | 10.00 |
| | 05000 OPERATING ROOM | 104, 535 | 802, 159 | | 357 | 50.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC | 3, 318 | 9, 390 171, 631 | 0 | 0 324 | 52.00 54.00 |
| | 05700 CT SCAN | 0 | 105, 144 | Ö | 126 | l . |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 20, 115 | 0 | 24 | 58.00 |
| 59. 00 60. 00 | 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY | 0 | 0 2, 109, 483 | 0 | 0 345 | |
| 60. 00 | 06000 EABORATORY | | 2, 109, 403 | 0 | 0 | |
| 65. 00 | 06500 RESPI RATORY THERAPY | 0 | 39, 452 | | 20 | |
| 66. 00 67. 00 | 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY | 0 | 42, 438 123 | | 13 | 66.00 |
| | 06800 SPEECH PATHOLOGY | | 123 | 0 | 2 | 68.00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0 | 64, 267 | 0 | 18 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 3, 652, 062 | 0 | 42 | 71.00 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | | 6, 098, 717 0 | 100 | 86 0 | |
| 76. 00 | 03950 CARDI AC REHAB | 5, 420 | 6, 067 | 0 | 3 | |
| | OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC | 114 002 | E7 222 | O | 12 | 99.00 |
| | 08801 RURAL HEALTH CLINIC | 114, 882 191, 322 | 57, 223 70, 730 | | 47 | 88. 00 88. 01 |
| 88. 02 | 08802 RURAL HEALTH CLINIC III | 19, 713 | 19, 586 | 0 | 0 | |
| | 09100 EMERGENCY | 66, 826 | 364, 925 | 0 | 372 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | | | | | 92.00 |
| | 10100 HOME HEALTH AGENCY | 0 | 26, 565 | 0 | 5 | 101.00 |
| 112 00 | SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE | | | | | 112.00 |
| | 11400 UTILIZATION REVIEW-SNF | | | | | 113.00 114.00 |
| 116.00 | 11600 HOSPI CE | 0 | 15, 412 | | 2 | 116.00 |
| 118. 00 | SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS | 681, 959 | 14, 182, 541 | 100 | 2, 179 | 118.00 |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | 190.00 |
| 192.00 | 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 0 | 0 | 0 | 192.00 |
| | 07950 HOSPI TALI ST | 0 | 0 | | 0 | |
| | 07951 RENTAL 07955 OTHER NONREIMBURSABLE COSTS | 0 | 0 | 0 | 0 | 194. 01 194. 05 |
| | 07956 DR AFZAL | o | Ö | Ö | 0 | 194.06 |
| | 07957 PHILLIPS HALL | 0 | 0 | 0 | 0 | 194. 07 |
| | 07958 0B DRS 07959 THE WATERS | 0 | 0 | 0 | 0 | 194. 08 194. 09 |
| | 07960 CAMBRI DGE CI TY | 0 | 0 | Ö | 0 | 194. 10 |
| | 07961 WELL BEING | 0 | 0 | 0 | 0 | 194. 11 |
| | 07962 ACTIVATE HEALTH EMPLOYER CLINIC 07963 NEW CASTLE PEDIATRICS | 0 | 0 | 0 | 0 | 194. 12 194. 13 |
| | 07964 HENRY COUNTY RADIOLOGY | | o | 0 | 0 | 194. 13 |
| 194. 15 | 07965 HENRY COUNTY ANESTHESI OLOGY | 0 | o | 0 | 0 | 194. 15 |
| | 07966 NEW CASTLE IMMEDICATE CARE & FAMILY | 0 | 0 | 0 | 0 | 194. 16 |
| 200. 00 201. 00 | Cross Foot Adjustments Negative Cost Centers | | | | | 200. 00 201. 00 |
| 202.00 | Cost to be allocated (per Wkst. B, | 4, 829, 943 | 1, 916, 992 | 5, 676, 723 | 1, 380, 215 | |
| 202.00 | | | | | | (I |
| 203. 00 | Part) Unit cost multiplier (Wkst. B, Part) | 7. 082454 | 0 1051// | 56, 767. 230000 | 633. 416705 | 203.00 |

| Heal th Fina | ncial Systems HI | ENRY COUNTY MEM | ORIAL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--------------|--|------------------|----------------|------------|----------------------------------|--------------------------------|---------|
| COST ALLOCA | TION - STATISTICAL BASIS | | Provi der Co | | Peri od: | Worksheet B-1 | |
| | | , | | | From 01/01/2021 To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
| | Cost Center Description | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | | |
| | | ADMI NI STRATI O | SERVICES & | (COSTED | RECORDS & | | |
| | | N | SUPPLY | REQUIS.) | LI BRARY | | |
| | | (DI RECT | (COSTED | | (TIME | | |
| | | NRSI NG HRS) | REQUIS.) | | SPENT) | | |
| | | 13. 00 | 14. 00 | 15.00 | 16.00 | | |
| 204. 00 | Cost to be allocated (per Wkst. B, | 151, 057 | 211, 798 | 80, 66 | 8 40, 758 | | 204. 00 |
| | Part II) | | | | | | |
| 205. 00 | Unit cost multiplier (Wkst. B, Part | 0. 221505 | 0. 014934 | 806. 68000 | 18. 704911 | | 205. 00 |
| 206. 00 | NAHE adjustment amount to be allocated | | | | | | 206. 00 |
| | (per Wkst. B-2) | | | | | | |
| 207. 00 | NAHE unit cost multiplier (Wkst. D, | | | | | | 207. 00 |
| | Parts III and IV) | | | | | | |
| | | | | | | | |

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

| | | Trovider ex | | From 01/01/2021 To 12/31/2021 | Part I Date/Time Pre 5/26/2022 3:4 | epared: |
|---|---|-----------------------|-------------|----------------------------------|--|-------------|
| | | Title | XVIII | Hospi tal | PPS | |
| | | | | Costs | | |
| Cost Center Description | Total Cost (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | Total Costs | RCE Di sal I owance | Total Costs | |
| | 1. 00 | 2. 00 | 3. 00 | 4.00 | 5. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 30. 00 03000 ADULTS & PEDIATRICS | 14, 074, 371 | | 14, 074, 37 | 1 0 | 14, 074, 371 | 30.00 |
| 31. 00 03100 INTENSIVE CARE UNIT | 5, 300, 351 | | 5, 300, 35 | | 5, 300, 351 | |
| | | | | | | |
| 43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS | 1, 352, 332 | | 1, 352, 33 | 2 0 | 1, 352, 332 | 43.00 |
| | 0.744 505 | | 9, 746, 50 | 5 0 | 9, 746, 505 | 50.00 |
| | 9, 746, 505 | | | | | 1 |
| | 448, 539 | | 448, 53 | | 448, 539 | |
| | 5, 072, 137 | | 5, 072, 13 | | 5, 072, 137 | |
| 57. 00 05700 CT SCAN | 855, 881 | | 855, 88 | | 855, 881 | 1 |
| 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 526, 047 | | 526, 04 | | 526, 047 | 1 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0 | | | 0 | 0 | 1 0 / 1 0 0 |
| 60. 00 06000 LABORATORY | 8, 767, 374 | | 8, 767, 37 | | 8, 767, 374 | |
| 60. 01 06001 BLOOD LABORATORY | 0 | _ | ' | 0 | 0 | |
| 65. 00 06500 RESPI RATORY THERAPY | 2, 248, 922 | 0 | , | | 2, 248, 922 | |
| 66. 00 06600 PHYSI CAL THERAPY | 3, 389, 525 | 0 | -,, | | 3, 389, 525 | |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 399, 686 | 0 | 399, 68 | | 399, 686 | 1 |
| 68. 00 06800 SPEECH PATHOLOGY | 156, 170 | 0 | 156, 17 | | 156, 170 | 1 |
| 69. 00 06900 ELECTROCARDI OLOGY | 590, 056 | | 590, 05 | | 590, 056 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 2, 173, 840 | | 2, 173, 84 | | 2, 173, 840 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 10, 735, 080 | | 10, 735, 08 | | 10, 735, 080 | 1 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 5, 676, 723 | | 5, 676, 72 | | 5, 676, 723 | 1 |
| 76. 00 03950 CARDI AC REHAB | 378, 564 | | 378, 56 | 4 0 | 378, 564 | 76. 00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 08800 RURAL HEALTH CLINIC | 9, 574, 439 | | 9, 574, 43 | | 9, 574, 439 | |
| 88. 01 08801 RURAL HEALTH CLINIC II | 16, 875, 071 | | 16, 875, 07 | 1 0 | 16, 875, 071 | 88. 01 |
| 88.02 08802 RURAL HEALTH CLINIC III | 1, 864, 715 | | 1, 864, 71 | 5 0 | 1, 864, 715 | 88. 02 |
| 91. 00 09100 EMERGENCY | 8, 764, 256 | | 8, 764, 25 | 33, 058 | 8, 797, 314 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 2, 291, 595 | | 2, 291, 59 | 5 | 2, 291, 595 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101.00 10100 HOME HEALTH AGENCY | 2, 285, 557 | | 2, 285, 55 | 7 | 2, 285, 557 | 101.00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 113. 00 11300 NTEREST EXPENSE | | | | | | 113.00 |
| 114.00 11400 UTI LI ZATI ON REVI EW-SNF | | | | | | 114.00 |
| 116. 00 11600 HOSPI CE | 1, 130, 313 | | 1, 130, 31 | 3 | 1, 130, 313 | |
| 200.00 Subtotal (see instructions) | 114, 678, 049 | 0 | | | | |
| 201.00 Less Observation Beds | 2, 291, 595 | Ĭ | 2, 291, 59 | | 2, 291, 595 | |
| 202.00 Total (see instructions) | 112, 386, 454 | 0 | | | | |
| | 1, 555, 161 | ı | 1, 555, 10 | ., 55, 666 | ,, 012 | 1-32.00 |

| neal tii Filla | rici ai systeiis ni | EINRT COUNTT WEW | UNIAL HUSFITAL | | III LI E | u or Form CM3 | 2332-10 |
|----------------|--|------------------|----------------|---|-----------------|-----------------------|---------|
| COMPUTATI ON | I OF RATIO OF COSTS TO CHARGES | | Provi der C | | Peri od: | Worksheet C | |
| | | | | | From 01/01/2021 | Part I | |
| | | | | | To 12/31/2021 | Date/Time Pre | eparea: |
| | | | T: +1 o | xVIII | Hospi tal | 5/26/2022 3: 4 PPS | 3 piii |
| | | | | XVIII | ноѕрі таі | PPS | |
| | | | Charges | I | | TEED. | |
| | Cost Center Description | I npati ent | Outpati ent | | Cost or Other | TEFRA | |
| | | | | + col. 7) | Ratio | I npati ent | |
| | | | | | | Ratio | |
| | | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| | TIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| | O ADULTS & PEDIATRICS | 11, 983, 630 | | 11, 983, 63 | 0 | | 30.00 |
| 31.00 0310 | O INTENSIVE CARE UNIT | 6, 391, 432 | | 6, 391, 43 | 2 | | 31.00 |
| 43.00 0430 | O NURSERY | 1, 774, 635 | | 1, 774, 63 | 5 | | 43.00 |
| | LLARY SERVICE COST CENTERS | | | | | • | Ī |
| | O OPERATING ROOM | 8, 100, 594 | 34, 771, 549 | 42, 872, 14 | 0. 227339 | 0.000000 | 50.00 |
| | DELIVERY ROOM & LABOR ROOM | 0 | 1, 278, 667 | | | | |
| | O RADI OLOGY-DI AGNOSTI C | 1, 726, 160 | 19, 129, 544 | | | 0. 000000 | |
| | O CT SCAN | 3, 645, 139 | 33, 037, 871 | | | 0. 000000 | |
| | O MAGNETIC RESONANCE IMAGING (MRI) | 528, 538 | 9, 532, 671 | | | | |
| | O CARDI AC CATHETERI ZATI ON | 320, 330 | 9, 332, 071 | | 0. 000000 | | |
| | O LABORATORY | 1 | 38, 049, 714 | | | | 1 |
| | | 11, 841, 521 | 38, 049, 714 | 49, 891, 23 | | l . | |
| | 1 BLOOD LABORATORY | 0 | 0 | | 0. 000000 | | |
| | O RESPIRATORY THERAPY | 4, 888, 748 | 3, 150, 765 | | | 0. 000000 | |
| | O PHYSI CAL THERAPY | 799, 207 | 4, 426, 619 | | | | |
| | O OCCUPATI ONAL THERAPY | 210, 438 | 635, 078 | | | | |
| | O SPEECH PATHOLOGY | 101, 690 | 221, 908 | 323, 59 | 0. 482605 | 0.000000 | |
| 69.00 0690 | O ELECTROCARDI OLOGY | 1, 576, 250 | 6, 003, 365 | 7, 579, 61 | 5 0. 077848 | 0.000000 | 69.00 |
| 71.00 0710 | O MEDICAL SUPPLIES CHARGED TO PATIENTS | 5, 492, 072 | 11, 647, 451 | 17, 139, 52 | 0. 126832 | 0.000000 | 71.00 |
| 72.00 0720 | OIMPL. DEV. CHARGED TO PATIENT | 11, 522, 230 | 23, 887, 025 | 35, 409, 25 | 0. 303172 | 0.000000 | 72.00 |
| 73.00 0730 | O DRUGS CHARGED TO PATIENTS | 7, 016, 785 | 6, 626, 780 | 13, 643, 56 | 0. 416073 | 0.000000 | 73.00 |
| 76. 00 03950 | O CARDI AC REHAB | 25, 737 | 1, 320, 122 | 1, 345, 85 | 9 0. 281281 | 0. 000000 | 76.00 |
| | ATIENT SERVICE COST CENTERS | | , , , , , | , | | | |
| | O RURAL HEALTH CLINIC | 0 | 4, 910, 785 | 4, 910, 78 | 5 | | 88. 00 |
| | 1 RURAL HEALTH CLINIC II | Ö | 19, 214, 658 | | | | 88. 01 |
| | 2 RURAL HEALTH CLINIC III | Ö | 1, 836, 665 | | | | 88. 02 |
| | O EMERGENCY | 6, 693, 918 | | | | 0. 000000 | |
| | O OBSERVATION BEDS (NON-DISTINCT PART) | 3, 452, 760 | | | | | |
| | | 3, 452, 760 | 8, 355, 447 | 11, 808, 20 | 7 0. 194068 | 0.000000 | 92.00 |
| | R REIMBURSABLE COST CENTERS | | 0.455.077 | 0 455 07 | , | | |
| | O HOME HEALTH AGENCY | 0 | 2, 155, 376 | 2, 155, 37 | 6 | | 101.00 |
| | I AL PURPOSE COST CENTERS | | | | | | 1 |
| | O INTEREST EXPENSE | | | | | | 113.00 |
| | OUTILIZATION REVIEW-SNF | | | | | | 114.00 |
| 116. 00 1160 | | 0 | 708, 562 | | | | 116.00 |
| 200. 00 | Subtotal (see instructions) | 87, 771, 484 | 279, 198, 585 | 366, 970, 06 | 9 | | 200.00 |
| 201. 00 | Less Observation Beds | | | | | | 201.00 |
| 202.00 | Total (see instructions) | 87, 771, 484 | 279, 198, 585 | 366, 970, 06 | 9 | | 202.00 |
| | | | | | 1 | 1 | |

| Cost Center Description | | | | To 12/31/2021 | Date/Time Prepared: 5/26/2022 3:43 pm | : |
|--|--|---------------|-------------|---------------|---------------------------------------|---|
| INPATI ENT ROUTINE SERVICE COST CENTERS 11 00 10 | | | Title XVIII | Hospi tal | | _ |
| INPATIENT ROUTINE SERVICE COST CENTERS 30.00 | Cost Center Description | PPS Inpatient | · | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS 30.00 31. | | Ratio | | | | |
| 30.00 | | 11. 00 | | | | |
| 31.00 03100 INTENSI VE CARE UNIT 31.00 A3.00 | | | | | | |
| 43.00 A300 NURSERY | 30. 00 03000 ADULTS & PEDI ATRI CS | | | | 30.00 | 0 |
| ANCI LLARY SERVICE COST CENTERS 50.00 | 31.00 03100 INTENSIVE CARE UNIT | | | | 31.00 | 0 |
| 50. 00 05000 05PERATING ROOM 0. 227339 50. 00 | | | | | 43.00 | 0 |
| 52.00 05200 DELI VERY ROOM & LABOR ROOM 0. 350786 52.00 | ANCILLARY SERVICE COST CENTERS | | | | | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 243201 57. 00 05700 CT SCAN 0. 023332 57. 00 05800 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 052285 58. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 0. 000000 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. 00000000 | | | | | | |
| 57. 00 | 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 350786 | | | 52.00 | 0 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0. 052285 58.00 05900 | 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 243201 | | | 54.00 | 0 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000 | 57.00 05700 CT SCAN | 0. 023332 | | | 57.00 | 0 |
| 60. 00 06000 LABORATORY 0. 175730 60. 00 60. 01 60. 01 BLOD LABORATORY 0. 000000 60. 01 60. 01 60. 00 60. | 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0. 052285 | | | 58.00 | 0 |
| 60. 01 06001 BLOOD LABORATORY 0. 000000 65. 00 65. 00 65. 00 RESPIRATORY THERAPY 0. 279734 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 484610 66. 00 06700 0CCUPATI ONAL THERAPY 0. 472713 67. 00 06700 0CCUPATI ONAL THERAPY 0. 472713 68. 00 06800 SPECH PATHOLOGY 0. 482605 68. 00 06900 ELECTROCARDI OLOGY 0. 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 126832 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 303172 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 303172 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 416073 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 281281 0. 07300 DRUGS CHARGED TO PATIENTS 0. 281281 0. 08800 RURAL HEALTH CLINIC 88. 01 08800 RURAL HEALTH CLINIC 11 88. 02 08802 RURAL HEALTH CLINIC 11 88. 01 09100 BERGEROCY 0. 159975 91. 00 09100 BERGEROCY 0. 194068 92. 00 07100 DRUGS COST CENTERS 0. 113. 00 11300 INTEREST EXPENSE 113. 00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 11600 HOSPI CE Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00 201. 00 201. 00 Less Observation Beds 201. 00 | 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0. 000000 | | | 59.00 | 0 |
| 65. 00 06500 RESPIRATORY THERAPY 0. 279734 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 648610 66. 00 67. 00 06700 0CUPATI ONAL THERAPY 0. 482605 68. 00 68. 00 06700 0CUPATI ONAL THERAPY 0. 482605 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 077848 69. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 126832 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 303172 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 416073 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 416073 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 416073 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 281281 00000000000000000000000000000000000 | 60. 00 06000 LABORATORY | 0. 175730 | | | 60.00 | 0 |
| 66. 00 06600 PHYSI CAL THERAPY 0. 648610 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 472713 67. 00 68. 00 06800 SPECH PATHOLOGY 0. 482605 68. 00 06900 ELECTROCARDI OLOGY 0. 077848 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 126832 71. 00 72.00 TO 0. 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 303172 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 416073 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 416073 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 416073 73. 00 08800 RURAL HEALTH CLI NI C 88. 01 88. 01 08801 RURAL HEALTH CLI NI C 11 88. 01 88. 02 08802 RURAL HEALTH CLI NI C 11 88. 01 88. 02 91. 00 9100 EMERGENCY 0. 159975 91. 00 9200 085ERVATI ON BEDS (NON-DI STI NCT PART) 0. 194068 92. 00 07100 HOME HEALTH AGENCY 0. 194068 92. 00 07100 HOME HEALTH AGENCY 0. 194068 92. 00 07100 HOME HEALTH AGENCY 0. 113. 00 11300 INTEREST EXPENSE 113. 00 11400 HOME HEALTH AGENCY 0. 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11600 HOSPI CE 0. 00 | 60. 01 06001 BLOOD LABORATORY | 0. 000000 | | | 60.0 | 1 |
| 67. 00 06700 0CCUPATI ONAL THERAPY 0. 472713 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 482605 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 0. 077848 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 126832 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0. 303172 72. 00 76. 00 03950 CARDI AC REHAB 0. 281281 76. 00 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C II 88. 01 88. 01 08801 RURAL HEALTH CLINI C II 88. 02 91. 00 09100 EMERGENCY 0. 159975 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 194068 0THER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 92. 00 101100 HOME HEALTH AGENCY 92. 00 101100 HOME HEALTH AGENCY 92. 00 101100 INTERREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 116. 00 1000 HOME LESS Observation Beds 201. 00 | 65. 00 06500 RESPIRATORY THERAPY | 0. 279734 | | | 65.00 | 0 |
| 68. 00 | 66. 00 06600 PHYSI CAL THERAPY | 0. 648610 | | | 66.00 | 0 |
| 69. 00 06900 ELECTROCARDIOLOGY 0. 077848 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 126832 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 303172 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 416073 73. 00 76. 00 03950 CARDIAC REHAB 0. 281281 76. 00 0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 88. 00 88. 01 08801 RURAL HEALTH CLINIC III 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 88. 02 91. 00 09100 EMERGENCY 0. 159975 91. 00 92. 00 07100 EMERGENCY 0. 194068 92. 00 000 THER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 92. 00 101. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTILIZATION REVIEW-SNF 114. 00 116. 00 11400 HOSPICE 1150 E 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds | 67. 00 06700 OCCUPATI ONAL THERAPY | 0. 472713 | | | 67.00 | 0 |
| 71. 00 | 68. 00 06800 SPEECH PATHOLOGY | 0. 482605 | | | 68.00 | 0 |
| 72. 00 | 69. 00 06900 ELECTROCARDI OLOGY | 0. 077848 | | | 69.00 | 0 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 416073 0. 281281 76. 00 76. 00 03950 CARDI AC REHAB 0. 281281 76. 00 OUTPATIENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC II 88. 01 08801 RURAL HEALTH CLINIC II 88. 02 08802 RURAL HEALTH CLINIC III 88. 02 09100 EMERGENCY 0. 159975 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 194068 92. 00 OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 92. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTILIZATION REVIEW-SNF 114. 00 116. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds | 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 126832 | | | 71.00 | 0 |
| 76. 00 03950 CARDI AC REHAB 0. 281281 88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II 88. 02 08802 RURAL HEALTH CLINIC III 91. 00 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 194068 101. 00 0THER REIMBURSABLE COST CENTERS 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 76. 00 88. 01 88. 00 88. 01 88. 00 98. 01 98. 01 99. 00 0. 159975 0. 194068 0. 194 | 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0. 303172 | | | 72.00 | 0 |
| SECOND SUBSTRATE SERVICE COST CENTERS SECOND SERVICE COST CENTERS SECOND | 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 416073 | | | 73.00 | 0 |
| 88. 00 88. 01 88. 01 88. 01 88. 02 88. 02 91. 00 92. 00 92. 00 07 HER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 113. 00 114. 00 114. 00 114. 00 114. 00 116. 00 200. 00 Subtotal (see instructions) Less Observation Beds 88. 00 88. 01 88. 01 88. 01 88. 01 88. 01 88. 02 91. 00 0. 159975 91. 00 0. 194068 92. 00 0. 194068 92. 00 101. 00 1 | 76. 00 03950 CARDI AC REHAB | 0. 281281 | | | 76.00 | 0 |
| 88. 01 | OUTPATIENT SERVICE COST CENTERS | | | | | |
| 88. 02 91. 00 91. 00 91. 00 92. 00 09200 DESERVATION BEDS (NON-DISTINCT PART) O. 159975 91. 00 07 O. 100 O. 10 | 88. 00 08800 RURAL HEALTH CLINIC | | | | 88. 00 | 0 |
| 91. 00 | 88. 01 08801 RURAL HEALTH CLINIC II | | | | 88. 0 | 1 |
| 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 194068 92. 00 0THER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11400 UTILIZATI ON REVIEW-SNF 114. 00 11400 HOME HEALTH AGENCY 114. 00 11400 UTILIZATI ON REVIEW-SNF 114. 00 116. 00 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00 | 88.02 08802 RURAL HEALTH CLINIC III | | | | 88. 02 | 2 |
| OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 114.00 1144.00 UTILLIZATION REVIEW-SNF 114.00 116.00 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 | 91. 00 09100 EMERGENCY | 0. 159975 | | | 91.00 | 0 |
| OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 114.00 1144.00 UTILLIZATION REVIEW-SNF 114.00 116.00 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 | 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 194068 | | | 92.00 | 0 |
| SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 114.00 11400 11410 UTI LI ZATI ON REVIEW-SNF 114.00 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 | OTHER REIMBURSABLE COST CENTERS | | | | | |
| 113. 00 | 101.00 10100 HOME HEALTH AGENCY | | | | 101.00 | 0 |
| 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116.00 116.00 1200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 | SPECIAL PURPOSE COST CENTERS | | | | | |
| 116. 00 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00 | 113. 00 11300 I NTEREST EXPENSE | | | | 113.00 | 0 |
| 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 | | | | | 114.00 | 0 |
| 201.00 Less Observation Beds 201.00 | 116. 00 11600 H0SPI CE | | | | 116.00 | 0 |
| | 200.00 Subtotal (see instructions) | | | | 200.00 | 0 |
| 202.00 Total (see instructions) 202.00 | 201.00 Less Observation Beds | | | | 201.00 | 0 |
| | 202.00 Total (see instructions) | | | | 202.00 | 0 |

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

From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared: 5/26/2022 3:43 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 14, 074, 371 14, 074, 371 0 14, 074, 371 30.00 03100 INTENSIVE CARE UNIT 5, 300, 351 5, 300, 351 0 5, 300, 351 31.00 31.00 43.00 04300 NURSERY 1, 352, 332 1, 352, 332 ol 1, 352, 332 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9, 746, 505 9, 746, 505 9, 746, 505 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 448, 539 448, 539 0 448, 539 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 5, 072, 137 5.072.137 5, 072, 137 54.00 57 00 05700 CT SCAN 855, 881 855, 881 855, 881 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 526, 047 526, 047 0 526, 047 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 0 06000 LABORATORY 60.00 8, 767, 374 8, 767, 374 8, 767, 374 60.00 60.01 06001 BLOOD LABORATORY Ω 60.01 06500 RESPIRATORY THERAPY 2, 248, 922 2, 248, 922 0 2, 248, 922 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 3, 389, 525 0 3, 389, 525 0 0 3, 389, 525 66.00 06700 OCCUPATI ONAL THERAPY 399, 686 C 399, 686 399, 686 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 156, 170 156, 170 156, 170 68.00 06900 ELECTROCARDI OLOGY 590, 056 590, 056 590, 056 69.00 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 2, 173, 840 2.173.840 2, 173, 840 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 10, 735, 080 10, 735, 080 10, 735, 080 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 676, 723 5, 676, 723 0 5, 676, 723 73.00 03950 CARDI AC REHAB 76.00 378, 564 378, 564 0 378, 564 76.00 OUTPATIENT SERVICE COST CENTERS 9, 574, 439 9, 574, 439 88.00 08800 RURAL HEALTH CLINIC 0 9, 574, 439 88.00 88.01 08801 RURAL HEALTH CLINIC II 16, 875, 071 16, 875, 071 0 16, 875, 071 88.01 08802 RURAL HEALTH CLINIC III 1, 864, 715 1, 864, 715 ol 1, 864, 715 88.02 88.02 09100 EMERGENCY 33, 058 91.00 8, 764, 256 8, 764, 256 8, 797, 314 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 291, 595 2, 291, 595 2, 291, 595 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 2, 285, 557 2, 285, 557 2, 285, 557 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 1, 130, 313 116. 00 1, 130, 313 1, 130, 313 114, 711, 107 200. 00 200.00 Subtotal (see instructions) 114, 678, 049 0 114, 678, 049 33, 058 201.00 Less Observation Beds 2, 291, 595 2, 291, 595 2, 291, 595 201. 00 202.00 Total (see instructions) 112, 386, 454 112, 386, 454 33, 058 112, 419, 512 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0030 Peri od: Worksheet C From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 3:43 pm Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 11 983 630 30.00 03000 ADULTS & PEDIATRICS 11, 983, 630 30.00 31.00 03100 INTENSIVE CARE UNIT 6, 391, 432 6, 391, 432 31.00 04300 NURSERY 1, 774, 635 1, 774, 635 43.00 43.00 ANCILLARY SERVICE COST CENTERS 0. 000000 8, 100, 594 50.00 34, 771, 549 42, 872, 143 0 227339 50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 278, 667 1, 278, 667 0. 350786 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 726, 160 19, 129, 544 20, 855, 704 0.243201 0.000000 54.00 05700 CT SCAN 33, 037, 871 3, 645, 139 36, 683, 010 0.023332 0.000000 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 528, 538 0.000000 58.00 9, 532, 671 10, 061, 209 0.052285 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0.000000 59.00 60.00 06000 LABORATORY 11, 841, 521 38, 049, 714 49, 891, 235 0.175730 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 65.00 06500 RESPIRATORY THERAPY 4, 888, 748 3, 150, 765 8, 039, 513 0.279734 0.000000 65.00 06600 PHYSI CAL THERAPY 799, 207 4, 426, 619 5, 225, 826 0.648610 66.00 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 635, 078 0.000000 67.00 845, 516 0.472713 67.00 210, 438 06800 SPEECH PATHOLOGY 68.00 101, 690 221, 908 323, 598 0.482605 0.000000 68 00 06900 ELECTROCARDI OLOGY 1, 576, 250 6,003,365 7, 579, 615 0.077848 0.000000 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 5, 492, 072 11, 647, 451 17, 139, 523 0.126832 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 23, 887, 025 72.00 11, 522, 230 35, 409, 255 0.303172 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 7, 016, 785 6, 626, 780 13, 643, 565 0.416073 0.000000 73.00 76.00 03950 CARDI AC REHAB 25, 737 1, 320, 122 1, 345, 859 0. 281281 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 4, 910, 785 88 00 08800 RURAL HEALTH CLINIC 4, 910, 785 1. 949676 0.000000 88 00 88.01 08801 RURAL HEALTH CLINIC II 0 19, 214, 658 19, 214, 658 0.878239 0.000000 88.01 08802 RURAL HEALTH CLINIC III 88.02 0 1,836,665 1, 836, 665 1.015272 0.000000 88.02 09100 EMERGENCY 6, 693, 918 48, 297, 963 54, 991, 881 0.159374 0.000000 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.194068 92.00 3, 452, 760 8, 355, 447 11, 808, 207 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 2, 155, 376 2, 155, 376 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 708, 562 708, 562 116.00 200 00 87, 771, 484 279, 198, 585 200 00 Subtotal (see instructions) 366, 970, 069 201.00 Less Observation Beds 201.00

87, 771, 484

279, 198, 585

366, 970, 069

202.00

202.00

Total (see instructions)

| Health Financial Systems | HENRY COUNTY MEMOR | IAL HOSPITAL | In Lieu | u of Form CMS-2552-10 |
|--|--------------------|-----------------------|--|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider CCN: 15-0030 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:43 pm |
| | | Title XIX | Hospi tal | Cost |
| Cost Contor Description | DDS Innationt | · | · · · · · · · · · · · · · · · · · · · | |

| | | | 10 12/31/2021 | 5/26/2022 3: 43 pm |
|--|---------------|-----------|---------------|--------------------|
| | | Title XIX | Hospi tal | Cost |
| Cost Center Description | PPS Inpatient | | <u> </u> | |
| · | Rati o | | | |
| | 11. 00 | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | · | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | | | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | | | | 31.00 |
| 43. 00 04300 NURSERY | 1 | | | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | |
| 50.00 05000 OPERATING ROOM | 0. 000000 | | | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | | | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | | | 54.00 |
| 57. 00 05700 CT SCAN | 0. 000000 | | | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0. 000000 | | | 58.00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0. 000000 | | | 59.00 |
| 60. 00 06000 LABORATORY | 0. 000000 | | | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0. 000000 | | | 60. 01 |
| 65. 00 06500 RESPIRATORY THERAPY | 0. 000000 | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 000000 | | | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0. 000000 | | | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0. 000000 | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | | | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0. 000000 | | | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | | | 73.00 |
| 76. 00 03950 CARDI AC REHAB | 0. 000000 | | | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | <u> </u> | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0. 000000 | | | 88.00 |
| 88.01 08801 RURAL HEALTH CLINIC II | 0. 000000 | | | 88. 01 |
| 88.02 08802 RURAL HEALTH CLINIC III | 0. 000000 | | | 88. 02 |
| 91. 00 09100 EMERGENCY | 0. 000000 | | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | · | | | |
| 101.00 10100 HOME HEALTH AGENCY | | | | 101.00 |
| SPECIAL PURPOSE COST CENTERS | | | | |
| 113. 00 11300 I NTEREST EXPENSE | | | | 113.00 |
| 114.00 11400 UTILIZATION REVIEW-SNF | | | | 114.00 |
| 116. 00 11600 HOSPI CE | | | | 116.00 |
| 200.00 Subtotal (see instructions) | | | | 200.00 |
| 201.00 Less Observation Beds | | | | 201.00 |
| 202.00 Total (see instructions) | | | | 202.00 |
| | | | | • |

| Health Financial Systems | ENRY COUNTY MEM | IORIAL HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|--|-----------------|-----------------|--------------|----------------------------|-----------------------|-----------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | COSTS | Provi der C | | Period: From 01/01/2021 | Worksheet D Part I | |
| | | | | Γο 12/31/2021 | | epared: 3 pm |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Swing Bed | Reduced | Total Patient | Per Diem | |
| | Related Cost | Adjustment | Capi tal | Days | (col. 3 / | |
| | (from Wkst. | | Related Cost | | col. 4) | |
| | B, Part II, | | (col. 1 - | | | |
| | col. 26) | | col. 2) | | | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 ADULTS & PEDIATRICS | 1, 116, 579 | 0 | 1, 116, 57 | 8, 623 | 129. 49 | 30.00 |
| 31.00 INTENSIVE CARE UNIT | 418, 465 | | 418, 46 | 2, 030 | 206. 14 | 31.00 |
| 43. 00 NURSERY | 99, 412 | | 99, 41: | 2 435 | 228. 53 | 43.00 |
| 200.00 Total (lines 30 through 199) | 1, 634, 456 | | 1, 634, 450 | 11, 088 | | 200.00 |
| Cost Center Description | I npati ent | I npati ent | | | | |
| | Program days | Program | | | | |
| | | Capital Cost | | | | |
| | | (col. 5 x | | | | |
| | | col. 6) | | | | |
| | 6. 00 | 7. 00 | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 ADULTS & PEDIATRICS | 2, 833 | | | | | 30.00 |
| 31.00 INTENSIVE CARE UNIT | 661 | 136, 259 | | | | 31.00 |
| 43. 00 NURSERY | 0 | 0 | | | | 43.00 |
| 200.00 Total (lines 30 through 199) | 3, 494 | 503, 104 | | | | 200. 00 |

| Health Financial Systems | HENRY COUNTY MEMORI | AL HOSPITAL | In Lie | u of Form CMS-2552-10 |
|---------------------------------|-----------------------------|-------------|--------|-----------------------|
| ADDODEL ONMENT OF INDATIONE AND | LLADY CEDIUSE CADLEAU COCTO | D | D | Western D |

| Health Financial Systems | ENRY COUNTY MEN | IORI AL HOSPI TAL | = | In Lie | u of Form CMS-2 | 2552-10 |
|--|-----------------|-------------------|------------|---|--|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT | AL COSTS | Provider C | | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Pre 5/26/2022 3:4 | |
| | | | XVIII | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Total Charges | | | Capital Costs | |
| | Related Cost | (from Wkst. | to Charges | Program | (column 3 x | |
| | (from Wkst. | C, Part I, | (col. 1 ÷ | Charges | column 4) | |
| | B, Part II, | col. 8) | col. 2) | | | |
| | col . 26) | | | | | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | 1 | | | |
| 50. 00 05000 OPERATI NG ROOM | 718, 314 | | | | l | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 47, 560 | | | | 0 | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 365, 568 | | | | | 54.00 |
| 57. 00 05700 CT SCAN | 21, 541 | | | | | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 19, 248 | 10, 061, 209 | | | l | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0 | | 0. 00000 | | 0 | 59.00 |
| 60. 00 06000 LABORATORY | 327, 507 | 49, 891, 235 | | | 29, 999 | 60.00 |
| 60. 01 06001 BL00D LABORATORY | 0 | · | 0.0000 | | 0 | 60. 01 |
| 65. 00 06500 RESPI RATORY THERAPY | 91, 554 | | | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 227, 295 | | 1 | | | 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 8, 370 | 845, 516 | 0.00989 | 103, 053 | 1, 020 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 6, 565 | 323, 598 | | | 1, 105 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 5, 557 | 7, 579, 615 | 0.00073 | 703, 873 | 516 | 69. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 66, 156 | 17, 139, 523 | 0.00386 | 2, 052, 471 | 7, 923 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 157, 239 | 35, 409, 255 | 0.00444 | 5, 165, 571 | 22, 940 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 80, 668 | 13, 643, 565 | 0.00591 | 13 2, 479, 527 | 14, 661 | 73.00 |
| 76. 00 03950 CARDI AC REHAB | 23, 762 | 1, 345, 859 | 0. 01765 | 8, 579 | 151 | 76. 00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 192, 688 | 4, 910, 785 | 0. 03923 | 38 0 | 0 | 88. 00 |
| 88.01 08801 RURAL HEALTH CLINIC II | 423, 788 | 19, 214, 658 | 0. 02205 | 55 0 | 0 | 88. 01 |
| 88.02 08802 RURAL HEALTH CLINIC III | 50, 523 | 1, 836, 665 | 0. 02750 | 0 8 | 0 | 88. 02 |
| 91. 00 09100 EMERGENCY | 395, 859 | 54, 991, 881 | 0.00719 | 2, 789, 286 | 20, 077 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 181, 801 | 11, 808, 207 | 0. 01539 | 820, 579 | 12, 634 | 92.00 |
| 200.00 Total (lines 50 through 199) | 3, 411, 563 | 343, 956, 434 | | 26, 757, 147 | 218, 771 | 200. 00 |

| Health Financial Systems | HENRY COUNTY MEN | MORIAL HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|--|------------------|-----------------|---------------|---|---|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER | PASS THROUGH COS | STS Provider C | | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part III Date/Time Pre 5/26/2022 3:4 | epared: |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Nursi ng | Nursi ng | Allied Health | Allied Health | All Other | |
| | Program | Program | Post-Stepdowr | Cost | Medi cal | |
| | Post-Stepdown | | Adjustments | | Educati on | |
| | Adjustments | | | | Cost | |
| | 1A | 1.00 | 2A | 2. 00 | 3. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 0 | 0 |) | 0 | 0 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 0 | 0 | | 0 | 0 | 31.00 |
| 43. 00 04300 NURSERY | 0 | 0 | | 0 | 0 | 43.00 |
| 200.00 Total (lines 30 through 199) | 0 | 0 |) | 0 | 0 | 200.00 |
| Cost Center Description | Swi ng-Bed | Total Costs | Total Patient | | I npati ent | |
| | Adjustment | (sum of cols. | Days | (col. 5 ÷ | Program Days | |
| | Amount (see | 1 through 3, | | col. 6) | | |
| | | minus col. 4) | | | | |
| | 4. 00 | 5. 00 | 6.00 | 7. 00 | 8. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | 1 |
| 30. 00 03000 ADULTS & PEDIATRICS | 0 | 0 | -, | | | |
| 31.00 03100 INTENSIVE CARE UNIT | | 0 | 2, 03 | | 661 | |
| 43. 00 04300 NURSERY | | 0 | 43 | | 0 | |
| 200.00 Total (lines 30 through 199) | | 0 | 11, 08 | 8 | 3, 494 | 200.00 |
| Cost Center Description | I npati ent | | | | | |
| | Program | | | | | |
| | Pass-Through | | | | | |
| | Cost (col. 7 | | | | | |
| | x col. 8) | _ | | | | |
| LANDATI ENT. DOUTLANS, OFFICE COOT, OFFITEDO | 9. 00 | | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | ı | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | | | | | 30.00 |
| 31. 00 03100 INTENSIVE CARE UNIT | 0 | | | | | 31.00 |
| 43. 00 04300 NURSERY | | | | | | 43.00 |
| 200.00 Total (lines 30 through 199) | 0 | ' | | | | 200. 00 |

Peri od: Worksheet D From 01/01/2021 Part IV To 12/31/2021 Date/Time Prepared: THROUGH COSTS

| | | | | | 10 12/31/2021 | 5/26/2022 3: 4 | |
|---------------|--|---------------|---------------|----------|---------------|----------------|---------|
| | | | Title | XVIII | Hospi tal | PPS | |
| | Cost Center Description | Non Physician | Nursi ng | Nursi ng | Allied Health | Allied Health | |
| | | Anesthetist | Program | Program | Post-Stepdown | | |
| | | Cost | Post-Stepdown | | Adjustments | | |
| | | | Adjustments | | | | |
| | | 1. 00 | 2A | 2.00 | 3A | 3. 00 | |
| | LLARY SERVICE COST CENTERS | | | | | | |
| 1 | O OPERATING ROOM | 0 | 0 | | 0 | 0 | 50.00 |
| | O DELIVERY ROOM & LABOR ROOM | 0 | 0 | | 0 | 0 | 52.00 |
| | O RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 | 0 | 54.00 |
| | O CT SCAN | 0 | 0 | | 0 | 0 | 57.00 |
| | O MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | | 0 | 0 | 58.00 |
| 4 | O CARDI AC CATHETERI ZATI ON | 0 | 0 | | 0 | 0 | 59. 00 |
| | 0 LABORATORY | 0 | 0 | | 0 | 0 | 60.00 |
| | 1 BLOOD LABORATORY | 0 | 0 | | 0 | 0 | 60. 01 |
| | O RESPI RATORY THERAPY | 0 | 0 | | 0 | 0 | 65.00 |
| | O PHYSI CAL THERAPY | 0 | 0 | | 0 | 0 | 66.00 |
| | O OCCUPATI ONAL THERAPY | 0 | 0 | | 0 | 0 | 67.00 |
| | O SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | 68.00 |
| | O ELECTROCARDI OLOGY | 0 | 0 | | 0 | 0 | 69. 00 |
| | O MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 | 0 | 71. 00 |
| | O IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | 0 | 0 | 72.00 |
| | O DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 | 0 | 73.00 |
| | O CARDI AC REHAB | 0 | 0 | | 0 0 | 0 | 76. 00 |
| | ATIENT SERVICE COST CENTERS | 1 | | ı | -1 | | |
| | O RURAL HEALTH CLINIC | 0 | 0 | | 0 | 0 | 88.00 |
| | 1 RURAL HEALTH CLINIC II | 0 | 0 | | 0 0 | 0 | 88. 01 |
| | 2 RURAL HEALTH CLINIC III | 0 | 0 | | 0 | 0 | 88. 02 |
| 91. 00 0910 | | 0 | 0 | | 0 | 0 | 91.00 |
| | O OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | | 0 | 0 | 92.00 |
| 200. 00 | Total (lines 50 through 199) | 0 | 0 | | 0 | 0 | 200. 00 |

| Health Financial Systems | HENRY COUNTY MEMORIA | AL HOSPITAL | In Lieu | ı of Form CMS-2552-10 |
|---------------------------------------|------------------------------|-----------------------|----------|-----------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT | ANCLLLARY SERVICE OTHER PASS | Provider CCN: 15-0030 | Peri od: | Worksheet D |

From 01/01/2021 | Part IV To 12/31/2021 | Date/Tim THROUGH COSTS Date/Time Prepared: 5/26/2022 3:43 pm Title XVIII Hospi tal Cost Center Description All Other Total Charges Ratio of Cost Total Cost Total to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 7. 00 4. 00 5.00 6.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 42, 872, 143 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 1, 278, 667 0.000000 52.00 52.00 0 0 0 0 0 0 0 0 0 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 20, 855, 704 0.000000 0 54.00 0 54.00 57. 00 05700 CT SCAN 0 0 36, 683, 010 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 10, 061, 209 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0.000000 59.00 0 49, 891, 235 60.00 06000 LABORATORY 0 0.000000 60.00 0 60.01 06001 BLOOD LABORATORY 0 0.000000 60.01 65.00 06500 RESPIRATORY THERAPY 8, 039, 513 0.000000 65.00 06600 PHYSI CAL THERAPY 0 0 5, 225, 826 0.000000 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0 0 845, 516 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 323, 598 0.000000 68.00 06900 ELECTROCARDI OLOGY 7, 579, 615 0.000000 69.00 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 17, 139, 523 0.000000 71 00 Ω 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 35, 409, 255 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 13, 643, 565 0.000000 73.00 03950 CARDI AC REHAB 0 76.00 0 1, 345, 859 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 0 0.000000 88.00 08800 RURAL HEALTH CLINIC 0 0 4, 910, 785 88.00 08801 RURAL HEALTH CLINIC II 19, 214, 658 0.000000 88.01 88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 1, 836, 665 0.000000 88.02 0 54, 991, 881 91. 00 09100 EMERGENCY 0 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 11, 808, 207 0 0.000000 92.00 Total (lines 50 through 199) 343, 956, 434 200.00 200.00

| Health Financial Systems | HENRY COUNTY MEMORI | AL HOSPITAL | In Lie | u of Form CMS-2552-10 |
|---|------------------------------|------------------------|--|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS | ANCILLARY SERVICE OTHER PASS | Provi der CCN: 15-0030 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/26/2022 3:43 pm |
| | | Title XVIII | Hospi tal | PPS |

| | | | 10 |) 12/31/2021 | 5/26/2022 3: 4 | |
|---|---------------|--------------|---------------|--------------|----------------|---------|
| | | 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 OPERATI NG ROOM | 0. 000000 | 3, 288, 536 | 0 | 8, 170, 828 | 0 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | 0 | 0 | 140, 848 | 0 | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | 764, 430 | 0 | 5, 133, 500 | 0 | 54.00 |
| 57.00 05700 CT SCAN | 0. 000000 | 1, 460, 066 | | 6, 933, 466 | 0 | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0. 000000 | 211, 096 | 0 | 2, 082, 764 | 0 | 58.00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0. 000000 | 0 | 0 | 0 | 0 | 59.00 |
| 60. 00 06000 LABORATORY | 0. 000000 | 4, 570, 189 | 0 | 2, 886, 543 | 0 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0. 000000 | 0 | 0 | 0 | 0 | 60. 01 |
| 65. 00 06500 RESPIRATORY THERAPY | 0. 000000 | 1, 912, 931 | 0 | 619, 406 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 000000 | 372, 503 | 0 | 33, 452 | 0 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0. 000000 | 103, 053 | 0 | 3, 002 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0. 000000 | 54, 457 | 0 | 5, 607 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | 703, 873 | 0 | 1, 693, 449 | 0 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | 2, 052, 471 | 0 | 2, 300, 537 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0. 000000 | 5, 165, 571 | 0 | 7, 354, 828 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | 2, 479, 527 | 0 | 1, 920, 161 | 0 | 73.00 |
| 76. 00 03950 CARDI AC REHAB | 0. 000000 | 8, 579 | 0 | 438, 347 | 0 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 08800 RURAL HEALTH CLINIC | 0. 000000 | 0 | 0 | 0 | 0 | 88. 00 |
| 88.01 08801 RURAL HEALTH CLINIC II | 0. 000000 | 0 | 0 | 0 | 0 | 88. 01 |
| 88.02 08802 RURAL HEALTH CLINIC III | 0. 000000 | 0 | 0 | 0 | 0 | 88. 02 |
| 91. 00 09100 EMERGENCY | 0. 000000 | 2, 789, 286 | 0 | 8, 524, 570 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | 820, 579 | 0 | 1, 905, 026 | 0 | 92.00 |
| 200.00 Total (lines 50 through 199) | | 26, 757, 147 | 0 | 50, 146, 334 | 0 | 200. 00 |
| | • | | · | · | | |

In Lieu of Form CMS-2552-10 Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0030 Peri od: Worksheet D From 01/01/2021 Part V 12/31/2021 Date/Time Prepared: 5/26/2022 3:43 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, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 227339 8, 170, 828 1, 857, 548 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.350786 52.00 140, 848 49, 408 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 5, 133, 500 0. 243201 1, 248, 472 54.00 57.00 05700 CT SCAN 0.023332 6, 933, 466 0 0 161, 772 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.052285 2, 082, 764 0 0 0 108, 897 58.00 0 59 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59 00 Ω 0 60.00 06000 LABORATORY 0.175730 2, 886, 543 507, 252 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 60.01 0 0 06500 RESPIRATORY THERAPY 0. 279734 619, 406 173, 269 65.00 65.00 0 06600 PHYSI CAL THERAPY 0.648610 33, 452 21, 697 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.472713 3,002 0 1, 419 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 0.482605 5, 607 2,706 68.00 0 1, 693, 449 06900 ELECTROCARDI OLOGY 0.077848 0 131, 832 69 00 69 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 126832 2, 300, 537 291, 782 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.303172 7, 354, 828 0 0 2, 229, 778 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.416073 1, 920, 161 0 410 798, 927 73.00 03950 CARDI AC REHAB 0 123, 299 76.00 0. 281281 438, 347 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88. 01 08801 RURAL HEALTH CLINIC II 88.01 08802 RURAL HEALTH CLINIC III 88 02 88 02 09100 EMERGENCY 91.00 0.159374 8, 524, 570 0 1, 358, 595 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.194068 1, 905, 026 0 369, 705 92.00 200.00 Subtotal (see instructions) 200.00 50, 146, 334 0 410 9, 436, 358 Less PBP Clinic Lab. Services-Program 0 201.00 0 201. 00

50, 146, 334

0

410

9, 436, 358 202. 00

Only Charges

Net Charges (line 200 - line 201)

202.00

From 01/01/2021 To 12/31/2021 Part V Date/Time Prepared: 5/26/2022 3:43 pm Titl<u>e XVIII</u> Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000 52.00 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 57.00 05700 CT SCAN 0 57.00 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 59 00 0 60.00 06000 LABORATORY 60.00 60.01 06001 BLOOD LABORATORY 60.01 0 65.00 06500 RESPIRATORY THERAPY 65.00 0 06600 PHYSI CAL THERAPY 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 69. 00 06900 ELECTROCARDI OLOGY 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 171 73.00 03950 CARDI AC REHAB 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08801 RURAL HEALTH CLINIC II 88.01 88.01 08802 RURAL HEALTH CLINIC III 88.02 88.02 09100 EMERGENCY 91.00 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 200.00 Subtotal (see instructions) 200.00 171 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

171

202.00

202.00

Net Charges (line 200 - line 201)

| Heal th | Financial Systems HENRY COUNTY | MEMORIAL HOSPITAL | In Lie | u of Form CMS-2 | 2552-10 |
|----------------------|---|-------------------------------|----------------------------------|-----------------|---------|
| | ATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Peri od: | Worksheet D-1 | |
| | | | From 01/01/2021 To 12/31/2021 | Date/Time Pre | |
| | | | | 5/26/2022 3: 4 | 3 pm |
| Title XVIII Hospital | | | | PPS | |
| | Cost Center Description | | | 1. 00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | 1.00 | |
| | I NPATI ENT DAYS | | | | 1 |
| 1.00 | Inpatient days (including private room days and swing-b | oed days, excluding newborn) | | 8, 623 | 1.00 |
| 2.00 | Inpatient days (including private room days, excluding | | | 8, 623 | 2.00 |
| 3. 00 | OD Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. | | | | |
| 4.00 | Semi-private room days (excluding swing-bed and observa | ation bed days) | | 7, 219 | 4.00 |
| 5. 00 | | | | | |
| 6. 00 | Total swing-bed SNF type inpatient days (including priv | | er 31 of the cost | 0 | 6. 00 |
| 7. 00 | reporting period (if calendar year, enter 0 on this lir Total swing-bed NF type inpatient days (including priva | | ber 31 of the cost | 0 | 7. 00 |
| 8. 00 | reporting period Total swing-bed NF type inpatient days (including priva | | er 31 of the cost | 0 | 8. 00 |
| 9. 00 | reporting period (if calendar year, enter 0 on this lir Total inpatient days including private room days applic | | ling swing-bed and | 2, 833 | 9. 00 |
| 10. 00 | newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title > | (VIII only (including privat | e room days) | 0 | 10.00 |
| 11. 00 | through December 31 of the cost reporting period (see instructions) | | | 0 | 11.00 |
| 12. 00 | December 31 of the cost reporting period (if calendar y Swing-bed NF type inpatient days applicable to titles \ | year, enter 0 on this line) | , | 0 | |
| | through December 31 of the cost reporting period | 3 1 0 1 | <i>y</i> , | 0 | |
| 13. 00 | Swing-bed NF type inpatient days applicable to titles $\mbox{\it N}$ after December 31 of the cost reporting period (if cale | endar year, enter 0 on this | line) | 0 | |
| 14. 00 | | | | | |
| 15.00 | Total nursery days (title V or XIX only) | | | 0 | |
| 16. 00 | Nursery days (title V or XIX only) | | | 0 | 16.00 |
| 17. 00 | SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to | considered through December 3 | 11 of the cost | 0.00 | 17. 00 |
| 17.00 | reporting period | services through becember 3 | or the cost | 0.00 | 17.00 |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to reporting period | services after December 31 | of the cost | 0. 00 | 18. 00 |
| 19. 00 | Medicald rate for swing-bed NF services applicable to s reporting period | services through December 31 | of the cost | 0. 00 | 19. 00 |
| 20. 00 | Medicaid rate for swing-bed NF services applicable to s | services after December 31 c | of the cost | 0. 00 | 20.00 |
| 21. 00 | reporting period Total general inpatient routine service cost (see instr | sustions) | | 14, 074, 371 | 21.00 |
| 22. 00 | Swing-bed cost applicable to SNF type services through | | orting period (line | | 1 |
| 23. 00 | 5 x line 17) Swing-bed cost applicable to SNF type services after De | ecember 31 of the cost repor | ting period (line 6 | 0 | 23. 00 |
| 24. 00 | | | | | 24. 00 |
| 25. 00 | 7 x line 19) 0 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 | | | | 25. 00 |
| 26. 00 | x line 20) Total swing-bed cost (see instructions) | | | | 26.00 |
| 27.00 | | looct (line 21 minus line 3 | (4) | 14 074 071 | 27 00 |

| | Cost Center Description | 1. 00 | |
|------------------|--|-------------------|------------------|
| | PART I - ALL PROVIDER COMPONENTS | 1.00 | |
| | INPATIENT DAYS | | |
| 1. 00 | Inpatient days (including private room days and swing-bed days, excluding newborn) | 8, 623 | 1.00 |
| 2. 00 | Inpatient days (including private room days, excluding swing-bed and newborn days) | 8, 623 | 2.00 |
| 3.00 | Private room days (excluding swing-bed and observation bed days). If you have only private room days, | 0 | 3.00 |
| | do not complete this line. | | |
| 4.00 | Semi-private room days (excluding swing-bed and observation bed days) | 7, 219 | 4.00 |
| 5.00 | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost | 0 | 5.00 |
| | reporting period | | |
| 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) | 2 022 | 9.00 |
| 9. 00 | Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) | 2, 833 | 9.00 |
| 10.00 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) | 0 | 10.00 |
| 10.00 | through December 31 of the cost reporting period (see instructions) | ٥ | 10.00 |
| 11. 00 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after | 0 | 11. 00 |
| | December 31 of the cost reporting period (if calendar year, enter 0 on this line) | - | |
| 12.00 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) | 0 | 12.00 |
| | through December 31 of the cost reporting period | | |
| 13.00 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) | 0 | 13.00 |
| | after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | |
| 14.00 | Medically necessary private room days applicable to the Program (excluding swing-bed days) | 0 | 14.00 |
| | Total nursery days (title V or XIX only) | 0 | 15.00 |
| 16. 00 | Nursery days (title V or XIX only) | 0 | 16. 00 |
| | SWING BED ADJUSTMENT | | |
| 17. 00 | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost | 0. 00 | 17. 00 |
| 10 00 | reporting period | 0.00 | 10.00 |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost | 0.00 | 18. 00 |
| 19. 00 | reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost | 0.00 | 19. 00 |
| 17.00 | reporting period | 0.00 | 19.00 |
| 20. 00 | | 0. 00 | 20. 00 |
| 20.00 | reporting period | 0.00 | 20.00 |
| 21.00 | | 14, 074, 371 | 21.00 |
| 22.00 | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line | 0 | 22. 00 |
| | 5 x line 17) | | |
| 23.00 | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line & | 0 | 23. 00 |
| | x line 18) | | |
| 24. 00 | | 0 | 24. 00 |
| | 7 x line 19) | _ | |
| 25. 00 | | 0 | 25. 00 |
| 24 00 | X line 20) | | 24 00 |
| 26. 00 27. 00 | 3 , | 0 14, 074, 371 | 26. 00 27. 00 |
| 27.00 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | 14, 074, 371 | 27.00 |
| 28 00 | General inpatient routine service charges (excluding swing-bed and observation bed charges) | 0 | 28. 00 |
| | Pri vate room charges (excluding swing-bed charges) | 0 | |
| 30.00 | Semi -pri vate room charges (excluding swing-bed charges) | 0 | |
| 31.00 | General inpatient routine service cost/charge ratio (line 27 ÷ line 28) | 0. 000000 | |
| 32. 00 | Average private room per diem charge (line 29 ÷ line 3) | 0. 00 | |
| 33. 00 | Average semi-private room per diem charge (line 3) + line 4) | 0. 00 | |
| 34.00 | Average per diem private room charge differential (line 32 minus line 33)(see instructions) | 0. 00 | |
| 35. 00 | Average per diem private room cost differential (line 34 x line 31) | 0. 00 | 1 |
| 36.00 | Private room cost differential adjustment (line 3 x line 35) | 0 | 36.00 |
| 37.00 | General inpatient routine service cost net of swing-bed cost and private room cost differential (line | 14, 074, 371 | 37.00 |
| | 27 minus line 36) | | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS | | |
| 38. 00 | Adjusted general inpatient routine service cost per diem (see instructions) | 1, 632. 19 | |
| 39. 00 | Program general inpatient routine service cost (line 9 x line 38) | 4, 623, 994 | |
| 40.00 | | 0 | 40.00 |
| 41.00 | Total Program general inpatient routine service cost (line 39 + line 40) | 4, 623, 994 | 41.00 |
| | | | |

| COMPUT | Financial Systems HE TATION OF INPATIENT OPERATING COST | NKY COUNTY MEM | ORIAL HOSPITAL Provider C | CN: 15-0030 | Peri od: | u of Form CMS-2 Worksheet D-1 | |
|------------------|---|----------------------------|----------------------------|--|----------------------------------|--------------------------------------|--|
| | | | | | From 01/01/2021 To 12/31/2021 | Date/Time Pre | |
| | | | Ti tl e | xVIII | Hospi tal | 5/26/2022 3: 4 PPS | 3 pm |
| | Cost Center Description | Total Inpatient Cost | Total Inpatient Days | Average Per Diem (col. 1 ÷ col. 2) | Program Days | Program Cost (col. 3 x col. 4) | |
| 42.00 | NURSERY (title V & XIX only) | 1. 00 | 2.00 | 3.00 | 4.00 | 5. 00 | 42.00 |
| 42.00 | Intensive Care Type Inpatient Hospital Units | | | 0.0 | 5 | Ü | 72.00 |
| | INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description | 5, 300, 351 | 2, 030 | 2, 611. 0 | 661 | 1, 725, 878 | 43. 00 44. 00 45. 00 46. 00 47. 00 |
| | <u> </u> | | | | | 1. 00 | |
| 48.00 | Program inpatient ancillary service cost (Wk | | | | | 6, 154, 171 | 1 |
| 49. 00 | Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS | 41 through 48) | (see Instructi | ons) | | 12, 504, 043 | 49. 00 |
| 50.00 | Pass through costs applicable to Program inp. | atient routine | services (fro | m Wkst. D, sun | of Parts I and | 503, 104 | 50.00 |
| 51.00 | Pass through costs applicable to Program inpland IV) | atient ancilla | ry services (f | rom Wkst. D, s | sum of Parts II | 218, 771 | 51.00 |
| 52. 00 | Total Program excludable cost (sum of lines | 50 and 51) | | | | 721, 875 | 52.00 |
| 53. 00 | Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION | | elated, non-ph | ysician anesth | etist, and | 11, 782, 168 | 53.00 |
| 54.00 | Program di scharges | | | | | 0 | 54.00 |
| 55.00 | | | | | | | 55.00 |
| 56. 00 57. 00 | Target amount (line 54 x line 55) Difference between adjusted inpatient operat | ing cost and ta | arget amount (| line 56 minus | line 53) | 0 | 1 |
| 58.00 | Bonus payment (see instructions) | | | | | 0 | |
| 59. 00 | Lesser of lines 53/54 or 55 from the cost remarket basket | porting period | endi ng 1996, | updated and co | empounded by the | 0.00 | 59.00 |
| 60.00 | Lesser of lines 53/54 or 55 from prior year | cost report, u | pdated by the | market basket | | 0.00 | 60.00 |
| 61.00 | If line 53/54 is less than the lower of line which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see | n expected cos | | | | 0 | 61.00 |
| | Relief payment (see instructions) | ŕ | | | | 0 | |
| 63.00 | Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST | ent (see Enstri | uctions) | | | 0 | 63.00 |
| 64. 00 | Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only) | ts through Dec | ember 31 of th | e cost reporti | ng period (See | 0 | 64.00 |
| 65. 00 | Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only) | ts after Decemb | ber 31 of the | cost reportino | period (See | 0 | 65. 00 |
| 66. 00 | Total Medicare swing-bed SNF inpatient routing CAH (see instructions) | ne costs (line | 64 plus line | 65)(title XVII | I only). For | 0 | 66. 00 |
| 67. 00 | Title V or XIX swing-bed NF inpatient routing (line 12 x line 19) | e costs through | h December 31 | of the cost re | eporting period | 0 | 67. 00 |
| 68. 00 | Title V or XIX swing-bed NF inpatient routing (line 13 x line 20) | e costs after l | December 31 of | the cost repo | orting period | 0 | 68. 00 |
| 69. 00 | Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N | | | | | 0 | 69.00 |
| 70.00 | Skilled nursing facility/other nursing facil | ity/ICF/IID row | utine service | cost (line 37) | | | 70.00 |
| 71. 00 72. 00 | Adjusted general inpatient routine service of Program routine service cost (line 9 x line | | ııne 70 ÷ line | 2) | | | 71.00 |
| 73.00 | Medically necessary private room cost applications | abĺe to Program | | | | | 73.00 |
| 74. 00 75. 00 | Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45) | • | | • | Part II, column | | 74.00 75.00 |
| 76. 00 | Per diem capital-related costs (line 75 ÷ li | ne 2) | | | | | 76.00 |
| 77.00 | Program capital -related costs (line 9 x line | | | | | | 77. 00 78. 00 |
| 78. 00 79. 00 | Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for excess | , | provi der recor | ds) | | | 79.00 |
| 80.00 | Total Program routine service costs for compa | arison to the | | , | nus 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 instructio | * . | | | | 83.00 |
| 84. 00 85. 00 | Program inpatient ancillary services (see in: Utilization review - physician compensation | | one) | | | | 84. 00 85. 00 |
| 86.00 | | • | | | | | 86.00 |
| | PART IV - COMPUTATION OF OBSERVATION BED PASS | S THROUGH COST | <u> </u> | | | | |
| 07 | Total observation bed days (see instructions |) | | | | 1, 404 | 87.00 |
| 87. 00 88. 00 | , | • | ÷ line 2) | | | 1, 632. 19 | 88. nn |

| Health Financial Systems H | ENRY COUNTY MEN | IORI AL HOSPI TAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|-------------------|------------|----------------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CO | | Peri od: | Worksheet D-1 | |
| | | | | From 01/01/2021 To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
| | | 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 | 1, 116, 579 | 14, 074, 371 | 0. 07933 | 4 2, 291, 595 | 181, 801 | 90.00 |
| 91.00 Nursing Program cost | 0 | 14, 074, 371 | 0.00000 | 0 2, 291, 595 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 14, 074, 371 | 0.00000 | 0 2, 291, 595 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 14, 074, 371 | 0. 00000 | 0 2, 291, 595 | 0 | 93.00 |

| Heal th | Financial Systems HENRY COUNTY MEMOR | I AL HOSPI TAL | In Lie | u of Form CMS-2 | 2552-10 |
|---------|---|--------------------------|--|---|---------|
| | TATION OF INPATIENT OPERATING COST | Provi der CCN: 15-0030 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet D-1 Date/Time Pre 5/26/2022 3:4 | pared: |
| | | Title XIX | Hospi tal | Cost | |
| | Cost Center Description | | | | |
| | <u> </u> | | | 1. 00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | | |
| | I NPATI ENT DAYS | | | | |
| 1.00 | Inpatient days (including private room days and swing-bed day | | | 8, 623 | |
| 2.00 | Inpatient days (including private room days, excluding swing- | | | 8, 623 | |
| 3. 00 | Private room days (excluding swing-bed and observation bed do not complete this line. | ays). If you have only p | rivate room days, | 0 | 3. 00 |
| 4.00 | Semi-private room days (excluding swing-bed and observation by | bed days) | | 7, 219 | 4.00 |
| 5. 00 | Total swing-bed SNF type inpatient days (including private reporting period | oom days) through Decemb | er 31 of the cost | 0 | 5. 00 |
| 6. 00 | Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line) | oom days) after December | 31 of the cost | 0 | 6. 00 |
| 7. 00 | Total swing-bed NF type inpatient days (including private rooreporting period | om days) through Decembe | er 31 of the cost | 0 | 7. 00 |
| 8. 00 | Total swing-bed NF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line) | om days) after December | 31 of the cost | 0 | 8. 00 |
| 9. 00 | Total inpatient days including private room days applicable newborn days) (see instructions) | to the Program (excludin | g swing-bed and | 267 | 9. 00 |
| 10. 00 | Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc | | room days) | 0 | 10.00 |
| 11. 00 | Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, or | only (including private | room days) after | 0 | 11.00 |
| 12. 00 | | | ite room days) | 0 | 12.00 |

| 3.00 | reporting period | O | 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 reporting period (if calendar year, enter 0 on this line) | 0 | 8. 00 |
| 9. 00 | Total inpatient days including private room days applicable to the Program (excluding swing-bed and | 267 | 9. 00 |
| 7. 00 | newborn days) (see instructions) | 207 | 7.00 |
| 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) | | |
| 11. 00 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after | 0 | 11. 00 |
| 12.00 | December 31 of the cost reporting period (if calendar year, enter 0 on this line) 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 | U | 12.00 |
| 13. 00 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) | 0 | 13. 00 |
| | after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | |
| 14.00 | Medically necessary private room days applicable to the Program (excluding swing-bed days) | 0 | 14.00 |
| 15. 00 | Total nursery days (title V or XIX only) | 435 | 15.00 |
| 16. 00 | Nursery days (title V or XIX only) | 0 | 16. 00 |
| 17.00 | SWING BED ADJUSTMENT | 0.00 | 47.00 |
| 17. 00 | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period | 0. 00 | 17. 00 |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost | 0. 00 | 18. 00 |
| | reporting period | | |
| 19. 00 | Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost | 0. 00 | 19. 00 |
| 20.00 | reporting period | 0.00 | 20.00 |
| 20. 00 | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period | 0. 00 | 20. 00 |
| 21. 00 | Total general inpatient routine service cost (see instructions) | 14, 074, 371 | 21. 00 |
| 22. 00 | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line | | 22. 00 |
| | 5 x line 17) | | |
| 23. 00 | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 | 0 | 23.00 |
| 24. 00 | x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line | 0 | 24. 00 |
| 24.00 | 7 x line 19) | O | 24.00 |
| 25.00 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 | 0 | 25.00 |
| | x line 20) | | |
| 26. 00 | Total swing-bed cost (see instructions) | 0 | 26.00 |
| 27. 00 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | 14, 074, 371 | 27. 00 |
| 28. 00 | General inpatient routine service charges (excluding swing-bed and observation bed charges) | 0 | 28. 00 |
| 29. 00 | Pri vate room charges (excluding swing-bed charges) | 0 | 29.00 |
| 30. 00 | Semi-private room charges (excluding swing-bed charges) | 0 | 30.00 |
| 31. 00 | General inpatient routine service cost/charge ratio (line 27 ÷ line 28) | 0.000000 | 31.00 |
| 32. 00 | Average private room per diem charge (line 29 ÷ line 3) | 0.00 | 32.00 |
| 33. 00 | Average semi-private room per diem charge (line 30 ÷ line 4) | 0. 00 | |
| 34. 00 | Average per diem private room charge differential (line 32 minus line 33)(see instructions) | 0. 00 | 34.00 |
| 35. 00 | Average per diem private room cost differential (line 34 x line 31) | 0.00 | 35. 00 |
| 36. 00 | Private room cost differential adjustment (line 3 x line 35) | 0 | 36.00 |
| 37. 00 | General inpatient routine service cost net of swing-bed cost and private room cost differential (line | 14, 074, 371 | 37.00 |
| | 27 minus line 36) | | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS | | |
| 38. 00 | Adjusted general inpatient routine service cost per diem (see instructions) | 1, 632. 19 | 38.00 |
| 39. 00 | Program general inpatient routine service cost (line 9 x line 38) | 435, 795 | 39.00 |
| 40.00 | Medically necessary private room cost applicable to the Program (line 14 x line 35) | 0 | 40.00 |
| 41.00 | Total Program general inpatient routine service cost (line 39 + line 40) | 435, 795 | 41.00 |
| | | | |

| COMPUT | Financial Systems HE ATION OF INPATIENT OPERATING COST | INIT COUNTY WEIN | ORI AL HOSPI TAL Provi der C | CN: 15-0030 | Peri od: | u of Form CMS-2 Worksheet D-1 | |
|------------------|---|----------------------------|---------------------------------|--|----------------------------------|--------------------------------------|------------------|
| | | | | | From 01/01/2021 To 12/31/2021 | Date/Time Pre | |
| | | | Ti tl | e XIX | Hospi tal | 5/26/2022 3: 4 Cost | 3 pm |
| | Cost Center Description | Total Inpatient Cost | Total Inpatient Days | Average Per Diem (col. 1 ÷ col. 2) | Program Days | Program Cost (col. 3 x col. 4) | |
| 42. 00 | NURSERY (title V & XIX only) | 1. 00 1, 352, 332 | 2.00 | 3. 00 3, 108. 8 | 4.00 | 5. 00 | 42.00 |
| .2. 00 | Intensive Care Type Inpatient Hospital Units | | | 37 133.3 | .1 | - | 1 .2. 0 |
| 43.00 | | 5, 300, 351 | 2, 030 | 2, 611. 0 | 1 0 | 0 | |
| 44. 00 45. 00 | CORONARY CARE UNIT BURN INTENSIVE CARE UNIT | | | | | | 44.00 |
| | SURGICAL INTENSIVE CARE UNIT | | | | | | 46.00 |
| | OTHER SPECIAL CARE (SPECIFY) | | | <u> </u> | | | 47.00 |
| | Cost Center Description | | | | | 1 00 | |
| 48. 00 | Program inpatient ancillary service cost (Wk | st. D-3. col. 3 | 3. line 200) | | | 1. 00 224, 996 | 48.00 |
| 49. 00 | , | | | ons) | | 660, 791 | |
| | PASS THROUGH COST ADJUSTMENTS | | | | | | |
| 50. 00 | Pass through costs applicable to Program inpa | atient routine | services (fro | n Wkst. D, sun | n of Parts I and |) | 50.00 |
| 51.00 | Pass through costs applicable to Program inpa | atient ancillar | rv services (f | com Wkst. D. s | sum of Parts II | o | 51.00 |
| | and IV) | | , | | | | |
| 52.00 | Total Program excludable cost (sum of lines! | | alatad t | vol ol on | -atiot | 0 | |
| 53. 00 | Total Program inpatient operating cost exclude medical education costs (line 49 minus line ! | | erated, non-pn | ysician anestr | netist, and | 0 | 53.00 |
| | TARGET AMOUNT AND LIMIT COMPUTATION | , | | | | | 1 |
| | Program di scharges | | | | | | 54.0 |
| 55. 00 56. 00 | | | | | | 0.00 | 55. 00 56. 00 |
| 57. 00 | Difference between adjusted inpatient operati | ing cost and ta | arget amount (| ine 56 minus | line 53) | 0 | 1 |
| 58. 00 | | 9 | , g | | | 0 | 1 |
| 59.00 | Lesser of lines 53/54 or 55 from the cost rep | porting period | endi ng 1996, | updated and co | ompounded by the | 0.00 | 59.00 |
| 60.00 | market basket Lesser of lines 53/54 or 55 from prior year | cost report un | odated by the i | market basket | | 0.00 | 60.00 |
| 61.00 | | | | | the amount by | 0 | 1 |
| | which operating costs (line 53) are less than | | ts (lines 54 x | 60), or 1% of | f the target | | |
| 62 00 | amount (line 56), otherwise enter zero (see i Relief payment (see instructions) | Instructions) | | | | 0 | 62.00 |
| | Allowable Inpatient cost plus incentive payme | ent (see instru | uctions) | | | Ö | |
| | PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | ļ |
| 64. 00 | Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only) | ts through Dece | ember 31 of the | e cost reporti | ng period (See | 0 | 64.00 |
| 65. 00 | Medicare swing-bed SNF inpatient routine cos | ts after Decemb | per 31 of the | cost reportino | g period (See | 0 | 65.00 |
| 66.00 | <pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre> | ne costs (line | 64 plus line | 55)(title XVII | ∐ only). For | 0 | 66.00 |
| 67. 00 | CAH (see instructions) Title V or XIX swing-bed NF inpatient routing | e costs through | n December 31 (| of the cost re | eportina period | 0 | 67.00 |
| 60 00 | (line 12 x line 19) Title V or XIX swing-bed NF inpatient routing | Ü | | | | | 68.00 |
| | (line 13 x line 20) | | | • | or tring period | | |
| 69.00 | Total title V or XIX swing-bed NF inpatient IPART III - SKILLED NURSING FACILITY, OTHER NU | | | | | U | 69.00 |
| 70.00 | Skilled nursing facility/other nursing facili | | | |) | | 70.00 |
| 71.00 | Adjusted general inpatient routine service co | , | ine 70 ÷ line | 2) | | | 71.00 |
| 72. 00 73. 00 | Program routine service cost (line 9 x line Medically necessary private room cost applications) | | n (line 14 v li | ine 35) | | | 72.00 |
| 74.00 | Total Program general inpatient routine servi | | | | | | 74.00 |
| 75. 00 | Capital-related cost allocated to inpatient 26, line 45) | • | | | Part II, column | | 75.00 |
| 76.00 | Per diem capital-related costs (line 75 ÷ li | ne 2) | | | | | 76.00 |
| 77.00 | Program capital -related costs (line 9 x line | | | | | | 77.0 |
| 78. 00 79. 00 | Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess | | orovider recor | ds) | | | 78. 0 79. 0 |
| 80. 00 | | , , | | , | nus line 79) | | 80.0 |
| 81.00 | Inpatient routine service cost per diem limi | | | | • | | 81.0 |
| 82.00 | | | * . | | | | 82.0 |
| 83. 00 84. 00 | Reasonable inpatient routine service costs (Program inpatient ancillary services (see in: | | 13) | | | | 83.0 |
| 85. 00 | Utilization review - physician compensation | | ons) | | | | 85. 0 |
| 86.00 | | | nrough 85) | | | | 86.0 |
| | PART IV - COMPUTATION OF OBSERVATION BED PASS | | | | | | |
| 87 00 | Total observation had days (see instructions) |) | | | , | 1 1 101 | 1 2 / // |
| 87. 00 88. 00 | Total observation bed days (see instructions Adjusted general inpatient routine cost per of | • | · line 2) | | | 1, 404 1, 632. 19 | |

| Health Financial Systems HE | ENRY COUNTY MEN | MORIAL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|-----------------|------------|----------------------------------|-----------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der CO | | Peri od: | Worksheet D-1 | |
| | | | | From 01/01/2021 To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
| | | Ti tl | e XIX | Hospi tal | Cost | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observation | |
| | | (from line | column 2 | Observation | Bed Pass | |
| | | 21) | | Bed Cost | Through Cost | |
| | | | | (from line | (col. 3 x | |
| | | | | 89) | col. 4) (see | |
| | | | | | instructions) | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital -related cost | 1, 116, 579 | 14, 074, 371 | 0. 07933 | 4 2, 291, 595 | 181, 801 | 90.00 |
| 91.00 Nursing Program cost | C | 14, 074, 371 | 0.00000 | 0 2, 291, 595 | 0 | 91.00 |
| 92.00 Allied health cost | C | 14, 074, 371 | 0.00000 | 0 2, 291, 595 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 14, 074, 371 | 0. 00000 | 0 2, 291, 595 | 0 | 93.00 |

| Health Financial Systems HENRY COUNTY MEMOR | | | In Lie | eu of Form CMS- | |
|---|--------------|--------------|----------------------------------|--------------------------------|---------------------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der C | CN: 15-0030 | Peri od: | Worksheet D-3 | 3 |
| | | | From 01/01/2021 To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | epared: |
| | Ti tl e | e XVIII | Hospi tal | PPS | |
| Cost Center Description | | Ratio of Cos | | I npati ent | |
| | | To Charges | Program | Program Costs | |
| | | | Charges | (col. 1 x | |
| | | 1.00 | | col . 2) | |
| LNDATI FAIT DOUTLAG CERVI OF COCT OFFITERS | | 1.00 | 2. 00 | 3. 00 | |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS | | | 4 740 050 | | |
| 30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT | | | 4, 743, 950 | | 30.00 |
| 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY | | | 2, 156, 940 | | 31. 00 43. 00 |
| ANCI LLARY SERVI CE COST CENTERS | | | | | 43.00 |
| 50. 00 05000 OPERATING ROOM | | 0. 2273 | 3, 288, 536 | 747, 612 | 50.00 |
| 52. 00 05200 DELI VERY ROOM & LABOR ROOM | | 0. 35078 | | 747,012 | 1 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | 0. 24320 | | _ | |
| 57. 00 05700 CT SCAN | | 0. 02333 | | | |
| 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) | | 0. 0522 | | | |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | | 0. 00000 | | | 1 |
| 60. 00 06000 LABORATORY | | 0. 1757: | | 803, 119 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | | 0.0000 | | 0 | |
| 65. 00 06500 RESPI RATORY THERAPY | | 0. 2797 | 1, 912, 931 | 535, 112 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 6486 | 10 372, 503 | 241, 609 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | 0. 4727 | 13 103, 053 | 48, 714 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | | 0. 48260 | 05 54, 457 | 26, 281 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0. 0778 | | | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0. 1268: | | | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | | 0. 3031 | | | |
| 73.00 O7300 DRUGS CHARGED TO PATIENTS | | 0. 4160 | | | |
| 76. 00 03950 CARDI AC REHAB | | 0. 2812 | 8, 579 | 2, 413 | 76. 00 |
| OUTPATIENT SERVICE COST CENTERS | | | | _ | |
| 88. 00 08800 RURAL HEALTH CLINIC | | 0.0000 | | 0 | |
| 88. 01 08801 RURAL HEALTH CLINIC II | | 0.0000 | | 0 | |
| 88. 02 08802 RURAL HEALTH CLINIC III | | 0.00000 | | 0 | |
| 91. 00 09100 EMERGENCY | | 0. 1599 | | | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0. 1940 | · · | | |
| Total (sum of lines 50 through 94 and 96 through 98) | c (line 41) | | 26, 757, 147 | | |
| 201.00 Less PBP Clinic Laboratory Services-Program only charge 202.00 Net charges (line 200 minus line 201) | s (iiile oi) | | 26, 757, 147 | | 201. 00 202. 00 |
| 202.00 Met charges (Title 200 IIII has Title 201) | | I | 20, 737, 147 | I | ₁ 202.00 |

| Health Financial Systems | | | | | | | |
|--|------------|---|-----------------------------|-------------|---------------|---------------|--------|
| Title XIX | | | | | | | |
| To 12/31/2021 Date/Time Prepared: 5/26/2022 3: 43 pm Four Pr | I NPATI EN | NT ANCILLARY SERVICE COST APPORTIONMENT | Provi der Co | CN: 15-0030 | | Worksheet D-3 | |
| Title XIX | | | | | | Data/Tima Dra | narod: |
| NPATIENT ROUTINE SERVICE COST CENTERS 1.00 | | | | | 10 12/31/2021 | | |
| NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 | | | Ti tl | e XIX | Hospi tal | | |
| NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3. | | Cost Center Description | | | t Inpatient | Inpati ent | |
| NPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 | | · · | | To Charges | Program | Program Costs | |
| INPATI ENT ROUTINE SERVICE COST CENTERS 292, 184 30. 00 31 | | | | | Charges | (col. 1 x | |
| INPATI ENT ROUTI NE SERVICE COST CENTERS 29, 184 30. 00 30. 00 3000 ADULTS & PEDIATRICS 167, 268 31. 00 31. 00 03100 INTENSIVE CARE UNIT 167, 268 31. 00 31. 00 03100 INTENSIVE CARE UNIT 203, 105 43. 00 43200 NURSERY 203, 105 43. 00 | | | | | | | |
| 30.00 | | | | 1.00 | 2. 00 | 3. 00 | |
| 31.00 03100 INTENSIVE CARE UNIT 167, 268 203, 105 43.00 04300 NURSERY 203, 105 43.00 43.00 04300 NURSERY 203, 105 43.00 43.00 050000 050000 050000 050000 050000 050000 050000 050000 0500000 0500000 05000000 0500000000 | | | | | | | |
| 43.00 | | | | | 292, 184 | | 30.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | 167, 268 | | 31.00 |
| 50. 00 | | | | | 203, 105 | | 43.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.350786 0 0.52.00 | | | | | | | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 243201 26, 162 6, 363 54. 00 57. 00 05700 CT SCAN 0. 023332 64, 809 1, 512 57. 00 58. 00 05800 MSMETI C RESONANCE IMAGING (MRI) 0. 052265 8, 774 459 58. 00 59. 00 05900 CARDIA C CATHETERI ZATI ON 0. 000000 0 0 59. 00 60. 01 06000 LABORATORY 0. 175730 257, 535 45, 257 60. 00 60. 01 06000 LABORATORY 0. 000000 0 0 60. 01 65. 00 06500 RESPI RATORY THERAPY 0. 279734 71, 636 20. 039 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 482605 546 20. 43 66. 00 67. 00 06700 OCCUPATIONAL THERAPY 0. 472713 1, 478 699 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 482605 546 264 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 07204 0. 07204 0. 07204 0. 07204 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>38, 040</td><td>50.00</td></td<> | | | | | | 38, 040 | 50.00 |
| 57. 00 05700 CT SCAN 0.023332 64,809 1,512 57.00 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0.052285 8,774 459 58.00 60.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0.000000 60.00 06000 LABORATORY 0.0175730 257,535 45,257 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 0 60.01 65.00 06500 RESPI RATORY THERAPY 0.279734 71,636 20,039 65.00 66.00 06600 PHYSI CAL THERAPY 0.472713 1,478 699 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0.472713 1,478 699 67.00 68.00 06800 SPECEH PATHOLOGY 0.472713 1,478 699 67.00 69.00 06900 ELECTROCARDI OLOGY 0.077848 22,187 1,727 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.126832 159,027 20,170 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.303172 0 0.720.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.416073 149,218 62,086 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.281281 275 777 76.00 0000 0000 0000 0000 0000 00000 88.01 088001 RURAL HEALTH CLINIC 1 0.878239 0 0.880.00 88.01 08801 RURAL HEALTH CLINIC 1 0.878239 0 0.880.00 88.02 08802 RURAL HEALTH CLINIC 1 0.878239 0 0.880.00 88.01 08800 RURAL HEALTH CLINIC 1 0.878239 0 0.880.00 88.02 08800 RURAL HEALTH CLINIC 1 0.878239 0 0.880.00 88.01 08800 RURAL HEALTH CLINIC 1 0.878239 0 0.880.00 88.02 08800 RURAL HEALTH CLINIC 1 0.878239 0 0.880.00 88.01 08800 RURAL HEALTH CLINIC 1 0.878239 0 0.880.00 88.02 08800 RURAL HEALTH CLINIC 1 0.878239 0 0.880.00 88.01 08800 RURAL HEALTH CLINIC 1 0.878239 0 0.880.00 88.02 08800 RURAL HEALTH CLINIC 1 0.878239 0 0.880.00 88.01 08800 RURAL HEALTH CLINIC 1 0.878239 0 0.880.00 88.02 08800 08800 08800 08800 08800 08800 08800 08800 08800 08800 08800 08800 08800 08800 08800 08800 08800 0880 | | | | | | 0 | 52.00 |
| 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.052285 8,774 459 58. 00 59. 00 05900 CARDIAC CATHETERIZATION 0.000000 0 0.59. 00 0.0000000 0.00000000 | | | | | | | |
| 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 59.00 60.00 60.000 LABORATORY 0.175730 257,535 45,257 60.00 60.00 06001 BLOOD LABORATORY 0.000000 0 0 60.01 65.00 06500 RESPIRATORY THERAPY 0.279734 71,636 20,039 65.00 66 | | | | | | | |
| 60. 00 06000 LABORATORY 0. 175730 257, 535 45, 257 60. 00 60. 01 06001 BLOOD LABORATORY 0. 0.000000 0 0 0 60. 01 65. 00 06500 RESPIRATORY THERAPY 0. 279734 71, 636 20, 039 65. 00 06600 PHYSI CAL THERAPY 0. 64. 00 06600 PHYSI CAL THERAPY 0. 4791 3, 107 66. 00 06700 0CCUPATI ONAL THERAPY 0. 472713 1, 478 699 67. 00 06800 SPEECH PATHOLOGY 0. 482605 546 264 68. 00 06900 ELECTROCARDI OLOGY 0. 077848 22, 187 1, 727 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 126832 159, 027 20, 170 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 303172 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0. 303172 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 416073 149, 218 62, 086 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 281281 275 77 76. 00 0880 RURAL HEALTH CLI NI C II 0. 878239 0 0 88. 01 08801 RURAL HEALTH CLI NI C II 1 0. 878239 0 0 88. 01 08801 RURAL HEALTH CLI NI C II 1 0. 878239 0 0 88. 01 08801 RURAL HEALTH CLI NI C II 1 0. 878239 0 0 88. 01 08801 RURAL HEALTH CLI NI C II 1 0. 878239 0 0 88. 01 08801 RURAL HEALTH CLI NI C II 1 0. 878239 0 0 88. 01 08801 RURAL HEALTH CLI NI C II 1 0. 878239 0 0 88. 01 08801 RURAL HEALTH CLI NI C II 1 0. 878239 0 0 88. 01 08801 RURAL HEALTH CLI NI C II 1 0. 878239 0 0 88. 01 08801 RURAL HEALTH CLI NI C II 1 0. 878239 0 0 88. 01 08801 RURAL HEALTH CLI NI C II 1 0. 878239 0 0 88. 01 08801 RURAL HEALTH CLI NI C II 1 0. 878239 0 0 88. 02 0. 00 09100 EMERGENCY 0. 159374 158, 092 25, 196 91. 00 09100 EMERGENCY 0. 159374 158, 092 25, 196 91. 00 09200 08SERVATI ON BEDS (NON-DISTINCT PART) 0. 194068 0 0 09200 00 08SERVATI ON BEDS (NON-DISTINCT PART) 0. 194068 0 0 000 000 000 000 000 000 000 000 | | | | | | 459 | |
| 60. 01 06001 BLOOD LABORATORY 0.000000 0 0 60. 01 | | | | | | | |
| 65.00 06500 RESPIRATORY THERAPY 0. 279734 71,636 20,039 65.00 66.00 06600 PHYSICAL THERAPY 0. 648610 4,791 3,107 66.00 67.00 06700 OCCUPATIONAL THERAPY 0. 472713 1,478 699 67.00 68.00 06800 SPEECH PATHOLOGY 0. 482605 546 264 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 077848 22,187 1,727 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 126832 159,027 20,170 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 303172 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 416073 149,218 62,086 73.00 76.00 03950 CARDI AC REHAB 0. 281281 275 77 76.00 00 | | | | | | 45, 257 | |
| 66. 00 06600 | | | | | | | |
| 67. 00 06700 0CCUPATI ONAL THERAPY 0.472713 1,478 699 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.482605 546 264 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.077848 22,187 1,727 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.126832 159,027 20,170 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.303172 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.416073 149,218 62,086 73. 00 76. 00 03950 CARDI AC REHAB 0.281281 275 77 76. 00 000 000 000 000 88. 01 08801 RURAL HEALTH CLINIC 1 0.878239 0 0 88. 00 88. 01 08802 RURAL HEALTH CLINIC 1 0.878239 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC 1 0.878239 0 0 88. 02 91. 00 09100 EMERGENCY 0.159374 158,092 25, 196 91. 00 920. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.194068 0 0 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 1,091,858 224,996 200. 00 201. 00 201. 00 | | | | | · · | · · | |
| 68. 00 | | | | | · · | | |
| 69. 00 06900 ELECTROCARDI OLOGY 0.077848 22, 187 1, 727 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.126832 159, 027 20, 170 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.303172 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.416073 149, 218 62, 086 73. 00 0.3950 CARDI AC REHAB 0.281281 275 77 76. 00 00000 00000 00000 00000 00000 00000 000 | | | | | | | |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.126832 159,027 20,170 71.00 72.00 72.00 72.00 72.00 72.00 73.00 | | | | | | | |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 303172 0 0 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 | | | | | | | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS 0.416073 149, 218 62, 086 73.00 76.00 03950 CARDI AC REHAB 0.281281 275 77 76.00 000 | | | | | | | |
| 76. 00 03950 CARDI AC REHAB 0. 281281 275 77 76. 00 00 00 00 00 00 00 00 00 00 00 00 00 | | | | | | | |
| SERVICE COST CENTERS SERVICE COST COST CENTERS SERVICE COST COST CENTERS SERVICE COST COST CENTERS SERVICE COST COST COST COST | | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC 1.949676 0 0.878239 0 0 0.88.01 0.8801 RURAL HEALTH CLINIC 1 0.878239 0 0 0.88.01 0.8802 RURAL HEALTH CLINIC 1 0.878239 0 0 0.88.01 0.8802 RURAL HEALTH CLINIC 1 0 0.8802 0.8802 RURAL HEALTH CLINIC 1 0 0 0 0 0 0 0 0 0 | | | | 0. 28128 | 31 275 | 77 | 76.00 |
| 88.01 08801 RURAL HEALTH CLINIC II 0.878239 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC II 0.15272 0 0 88.02 91.00 09100 EMERGENCY 0.159374 158,092 25,196 91.00 92.00 085ERVATION BEDS (NON-DISTINCT PART) 0.194068 0 0 92.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 0.878239 0 0 88.01 0.878239 0 0 88.01 0.15272 0 0 88.02 0.159374 0.159374 0.159374 0.194068 0 0 92.00 0.194068 0 0 0.878239 0 0 0.878239 0 0 0.159374 0.159374 0.159374 0.194068 0 0 0.194068 0 0 0.194068 0 0.194068 0 0.194068 0.19406 | | | | | | | |
| 88.02 08802 RURAL HEALTH CLINIC III 1.015272 0 0 88.02 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.194068 0 92.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 0 20 | | | | | | - | |
| 91. 00 09100 EMERGENCY 0. 159374 158, 092 25, 196 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 194068 0 92. 00 201. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201. 00 201. 00 0. 159374 0. 159374 0. 159374 0. 194068 0 92. 00 92. 00 201. 00 2 | | | | | | | |
| 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.194068 0 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 1,091,858 224,996 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 | | | | | | _ | |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98) 1,091,858 224,996 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 | | | | | | 1 | |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 | | | | 0. 19406 | | _ | |
| | | | | | 1, 091, 858 | 224, 996 | 1 |
| 202.00 Net charges (Fine 200 minus Fine 201) 1,091,858 202.00 | | | gram only charges (line 61) | | 0 | | |
| | 202.00 | Net charges (line 200 minus line 201) | | | 1, 091, 858 | | 202.00 |

| Health Financial Systems | HENRY COUNTY MEMORIAL HOSPITAL | In Lie | u of Form CMS-2552-10 |
|---|--------------------------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0030 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Date/Time Prepared: 5/26/2022 3:43 pm |

| | | | To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
|------------------|--|--------------------------|--------------------|-----------------------------|----------------|
| | | Title XVIII | Hospi tal | PPS | 5 piii |
| | | | | 1. 00 | |
| | PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS | | | 1.00 | |
| 1.00 | DRG Amounts Other than Outlier Payments | | | 0 | 1.00 |
| 1. 01 | DRG amounts other than outlier payments for discharges occurr | ing prior to October 1 | (see | 5, 647, 746 | 1. 01 |
| 1. 02 | instructions) DRG amounts other than outlier payments for discharges occurr | ing on or after October | 1 (see | 1, 939, 860 | 1. 02 |
| 1. 03 | <pre>instructions) DRG for federal specific operating payment for Model 4 BPCl for discharges occurring prior to October 1 (see instructions)</pre> | | | | 1.03 |
| 1. 04 | DRG for federal specific operating payment for Model 4 BPCI f | or discharges occurring | on or after | 0 | 1. 04 |
| 2.00 | October 1 (see instructions) Outlier payments for discharges. (see instructions) | | | 0 | 2.00 |
| 2. 01 2. 02 | Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct | i ons) | | 0 | 2. 01 2. 02 |
| 2. 02 | Outlier payments for discharges occurring prior to October 1 | • | | 24, 941 | |
| 2.04 | Outlier payments for discharges occurring on or after October | | | 536 | 2.04 |
| 3.00 | Managed Care Simulated Payments | | | 0 | |
| 4. 00 | Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment | rting period (see instr | uctions) | 44. 03 | 4.00 |
| 5. 00 | FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions) | t recent cost reporting | peri od endi ng or | 0.00 | 5.00 |
| 6. 00 | FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e) | he criteria for an add-o | on to the cap for | 0.00 | 6. 00 |
| 7.00 | MMA Section 422 reduction amount to the IME cap as specified | under 42 CFR §412.105(f) | (1)(iv)(B)(1) | 0. 00 | 7.00 |
| 7. 01 | ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions. | 42 CFR §412.105(f)(1)(i | v)(B)(2) If the | 0. 00 | 7. 01 |
| 8. 00 | Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. | | | 0. 00 | 8. 00 |
| 8. 01 | 1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sl | ots under § 5503 of the | ACA. If the cost | 0. 00 | 8. 01 |
| 8. 02 | report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap sl | ots from a closed teachi | ng hospital | 0. 00 | 8. 02 |
| 9. 00 | under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions) | es (8, 8,01 and 8,02) | (see | 0. 00 | 9. 00 |
| 10.00 | FTE count for allopathic and osteopathic programs in the curr | ent year from your reco | rds | 0.00 | 10.00 |
| | FTE count for residents in dental and podiatric programs. | 3 | | 0.00 | 11.00 |
| | , , , | | | 0.00 | |
| | Total allowable FTE count for the prior year. | or anded on or ofter Co | stambar 20 1007 | 0.00 | 1 |
| 14. 00 | Total allowable FTE count for the penultimate year if that ye otherwise enter zero. | ar ended on or arter sep | Telliber 30, 1997, | 0. 00 | 14.00 |
| 15.00 | Sum of lines 12 through 14 divided by 3. | | | 0.00 | 15.00 |
| | Adjustment for residents in initial years of the program | | | | 16. 00 |
| | Adjustment for residents displaced by program or hospital clo | sure | | | 17.00 |
| 18.00 | Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4 | ` | | 0. 00 0. 000000 | |
| | Prior year resident to bed ratio (fine 16 divided by fine 4 |). | | 0.000000 | |
| | Enter the lesser of lines 19 or 20 (see instructions) | | | 0. 000000 | |
| | IME payment adjustment (see instructions) | | | 0 | 22.00 |
| 22. 01 | IME payment adjustment - Managed Care (see instructions) | | | 0 | 22. 01 |
| 23. 00 | Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional allopathic and osteopathic IME FTE resid | | CFR 412. 105 | 0.00 | 23. 00 |
| 24. 00 | (f)(1)(iv)(C). 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 | e 24 (see | 0. 00 | |
| 24 00 | instructions) | | | 0.000000 | 24 00 |
| 26. 00 27. 00 | Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions) | | | 0. 000000 0. 000000 | |
| | IME add-on adjustment amount (see instructions) | | | 0.000000 | 1 |
| | IME add-on adjustment amount - Managed Care (see instructions |) | | 0 | 1 |
| | Total IME payment (sum of lines 22 and 28) | | | 0 | |
| 29. 01 | Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment | 1) | | 0 | 29. 01 |
| 30.00 | Percentage of SSI recipient patient days to Medicare Part A p | atient days (see instru | ctions) | 4. 25 | 30.00 |
| | Percentage of Medicaid patient days (see instructions) | J = (= 7 = 1 = 1 | ŕ | 17. 47 | 1 |
| 32.00 | Sum of lines 30 and 31 | | | 21. 72 | 1 |
| | Allowable disproportionate share percentage (see instructions |) | | 7. 14 | 1 |
| 34.00 | Disproportionate share adjustment (see instructions) | | l | 135, 439 | 34.00 |

| | Financial Systems HENRY COUNTY MEN ATION OF REIMBURSEMENT SETTLEMENT | MORIAL HOSPITAL Provider CCN: 15-0030 | Peri od: | u of Form CMS-2 | 2552-10 |
|------------------|--|---------------------------------------|----------------------------|------------------------|------------------|
| CALCUL | ATION OF KETMBUKSEMENT SETTLEMENT | Provider CCN: 15-0030 | Period: From 01/01/2021 | Worksheet E Part A | |
| | | | To 12/31/2021 | Date/Time Pre | |
| | | Title XVIII | Hospi tal | 5/26/2022 3: 4 PPS | 3 piii |
| | | | Prior to 10/1 | | |
| | T | | 1. 00 | 2. 00 | |
| 25 00 | Uncompensated Care Adjustment | | 0 | 0 | 25 00 |
| 35. 00 35. 01 | Total uncompensated care amount (see instructions) Factor 3 (see instructions) | | 0. 000000000 | 0. 000000000 | |
| 35. 02 | | nter zero on this line) (s | | 590, 026 | 1 |
| | instructions) | | , , | | |
| 35. 03 | | | 332, 536 | 148, 719 | 1 |
| 36. 00 | Total uncompensated care (sum of columns 1 and 2 on line 3 | | 481, 255 | | 36.00 |
| 40. 00 | Additional payment for high percentage of ESRD beneficiary Total Medicare discharges (see instructions) | discharges (Times 40 third | 0 (Jugn 46) | | 40.00 |
| 41. 00 | Total ESRD Medicare discharges (see instructions) | | 0 | | 41.00 |
| 41. 01 | Total ESRD Medicare covered and paid discharges (see instr | uctions) | 0 | | 41.01 |
| 42.00 | Divide line 41 by line 40 (if less than 10%, you do not qu | alify for adjustment) | 0. 00 | | 42.00 |
| 43.00 | Total Medicare ESRD inpatient days (see instructions) | | 0 | | 43.00 |
| 44. 00 | Ratio of average length of stay to one week (line 43 divid | ed by line 41 divided by T | 0.000000 | | 44.00 |
| 45. 00 | days) Average weekly cost for dialysis treatments (see instructi | ons) | 0.00 | | 45.00 |
| 46. 00 | , , | | 0.00 | | 46.00 |
| 47. 00 | 1 3 1 | | 8, 229, 777 | | 47. 00 |
| 48. 00 | Hospital specific payments (to be completed by SCH and MDH | , small rural hospitals | 9, 656, 274 | | 48. 00 |
| | only. (see instructions) | | | | |
| | | | | Amount 1.00 | |
| 49. 00 | Total payment for inpatient operating costs (see instructi | ons) | | 9, 299, 650 | 49.00 |
| 50.00 | Payment for inpatient program capital (from Wkst. L, Pt. I | * | e) | 574, 682 | 50.00 |
| 51. 00 | | | | 0 | |
| 52.00 | Direct graduate medical education payment (from Wkst. E-4, | line 49 see instructions | ١. | 0 | |
| 53. 00 54. 00 | Nursing and Allied Health Managed Care payment Special add-on payments for new technologies | | | 0 246, 902 | 53.00 54.00 |
| 54. 01 | Islet isolation add-on payment | | | 240, 902 | 54.00 |
| 55. 00 | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin | e 69) | | 0 | 55.00 |
| 56. 00 | Cost of physicians' services in a teaching hospital (see i | | | 0 | 56.00 |
| 57.00 | Routine service other pass through costs (from Wkst. D, Pt | | through 35). | 0 | 57.00 |
| 58.00 | Ancillary service other pass through costs from Wkst. D, P | t. IV, col. 11 line 200) | | 0 | |
| 59. 00 60. 00 | Total (sum of amounts on lines 49 through 58) Primary payer payments | | | 10, 121, 234 0 | 60.00 |
| 61. 00 | Total amount payable for program beneficiaries (line 59 mi | nus Line 60) | | 10, 121, 234 | |
| 62. 00 | Deductibles billed to program beneficiaries | | | 990, 020 | 1 |
| 63. 00 | Coinsurance billed to program beneficiaries | | | 0 | 63.00 |
| 64. 00 | Allowable bad debts (see instructions) | | | 67, 767 | |
| 65.00 | Adjusted reimbursable bad debts (see instructions) | notruoti ono) | | 44, 049 | |
| 67.00 | Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) | nstructions) | | 41, 746 9, 175, 263 | |
| 68. 00 | Credits received from manufacturers for replaced devices f | for applicable to MS-DRGs | (see instructions) | | l l |
| | Outlier payments reconciliation (sum of lines 93, 95 and 9 | | | 0 | |
| 70. 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | |
| 70. 50 | Rural Community Hospital Demonstration Project (§410A Demo | , , | e instructions) | 0 | |
| 70.87 | Demonstration payment adjustment amount before sequestrati | | | 0 | 70.87 |
| 70. 88 70. 89 | SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see i | | | 0 | 70. 88 70. 89 |
| 70. 89 | · · · · · · · · · · · · · · · · · · · | • | | 3, 119 | 1 |
| | HSP bonus payment HRR adjustment amount (see instructions) | • | | -27, 970 | |
| 70. 91 | In a Hart Market of the state o | | | 0 | 70. 92 |
| 70. 92 | , | | | | |
| | HVBP payment adjustment amount (see instructions) | | | 22, 713 -204, 334 | 70. 93 |

| | Financial Systems HENRY COUNTY MEMORIA | | | | u of Form CMS-2 | 2552-10 |
|---------|---|-------------|-------------|-----------------------------|-----------------------|---------|
| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provi der C | CN: 15-0030 | Peri od: From 01/01/2021 | Worksheet E Part A | |
| | | | | To 12/31/2021 | | pared: |
| | | | | | 5/26/2022 3:4 | |
| | | Title | XVIII | Hospi tal | PPS | |
| | | | FFY | (yyyy) | Amount | |
| 70.01 | The second control of | | | 0 | 1. 00 | 70.0 |
| 70. 96 | Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1) | column 0 | | 2021 | 864, 335 | 70. 90 |
| 70. 97 | Low volume adjustment for federal fiscal year (yyyy) (Enter in | column 0 | | 2022 | 301, 637 | 70. 9 |
| 70. 77 | the corresponding federal year for the period ending on or after | | | 2022 | 301, 037 | 70.9 |
| 70. 98 | Low Volume Payment-3 | Ci 10/1) | | | 0 | 70. 9 |
| 70. 99 | HAC adjustment amount (see instructions) | | | | 0 | |
| | Amount due provider (line 67 minus lines 68 plus/minus lines 69 | 9 & 70) | | | 10, 134, 763 | |
| 71. 01 | Seguestration adjustment (see instructions) | | | | 0 | |
| 71. 02 | Demonstration payment adjustment amount after sequestration | | | | 0 | 71.0 |
| 71. 03 | Sequestration adjustment-PARHM pass-throughs | | | | | 71.0 |
| 72. 00 | Interim payments | | | | 10, 126, 566 | 72.0 |
| 72. 01 | Interim payments-PARHM | | | | | 72.0 |
| 73. 00 | Tentative settlement (for contractor use only) | | | | 0 | 73.0 |
| 73. 01 | Tentative settlement-PARHM (for contractor use only) | | | | | 73.0 |
| 74. 00 | Balance due provider/program (line 71 minus lines 71.01, 71.02, 73) | , 72, and | | | 8, 197 | 74.0 |
| 74. 01 | Balance due provider/program-PARHM (see instructions) | | | | | 74.0 |
| 75.00 | Protested amounts (nonallowable cost report items) in accordance | ce with | | | 174, 683 | 75.00 |
| | CMS Pub. 15-2, chapter 1, §115.2 | | | | | |
| | TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) | | | | | |
| 90. 00 | Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of | f 2.03 | | | 0 | 90.0 |
| 91. 00 | plus 2.04 (see instructions) Capital outlier from Wkst. L, Pt. I, line 2 | | | | 0 | 91.0 |
| | Operating outlier reconciliation adjustment amount (see instruc | ctions) | | | 0 | |
| | Capital outlier reconciliation adjustment amount (see instructi | , | | | 0 | |
| | The rate used to calculate the time value of money (see instructions) | | | | 0.00 | 1 ,0.0 |
| 95.00 | Time value of money for operating expenses (see instructions) | 0110113) | | | 0.00 | |
| 96.00 | Time value of money for capital related expenses (see instructi | i ons) | | | 0 | |
| | | | • | Prior to 10/1 | On/After 10/1 | |
| | | | | 1. 00 | 2. 00 | |
| | HSP Bonus Payment Amount | | | | | |
| 100.00 | HSP bonus amount (see instructions) | | | 800, 206 | 269, 667 | 100.00 |
| | HVBP Adjustment for HSP Bonus Payment | | | | | 1 |
| | HVBP adjustment factor (see instructions) | | | 1. 0038973054 | 1. 0000000000 | |
| 102.00 | HVBP adjustment amount for HSP bonus payment (see instructions) |) | | 3, 119 | 0 | 102.00 |
| 102 00 | HRR Adjustment for HSP Bonus Payment | | | 0.0700 | 0.0050 | 100 0 |
| | HRR adjustment factor (see instructions) | | | 0. 9700 | | |
| 104.00 | HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra | ation) Adi | ustmont | -24, 006 | -3, 964 | 1104.00 |
| 200 00 | Is this the first year of the current 5-year demonstration peri | | | | | 200. 00 |
| 200. UC | Century Cures Act? Enter "Y" for yes or "N" for no. | i ou unuel | the ZISt | | | 200.00 |
| | Cost Reimbursement | | | | | |
| 201 00 | Medicare inpatient service costs (from Wkst D-1 Pt II line | | | | | 201 0 |

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 In Lieu of Form CMS-2552-10 Peri od: Worksheet E From 01/01/2021 Part A Exhi bi t 4 To 12/31/2021 Date/Time Prepared Provi der CCN: 15-0030

| | | | | | | o 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | pared: |
|------------------|--|--------------------------|-----------------------------|-------------------------|--------------------------|------------------------------|-----------------------------|----------|
| | | | | Title | XVIII | Hospi tal | PPS | <u> </u> |
| | | W/S E, Part A line | Amounts (from E, Part A) | Pre/Post Entitlement | Period Prior to 10/01 | Peri od On/After 10/01 | Total (Col 2 through 4) | |
| | | 0 | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 1. 00 | DRG amounts other than outlier | 1. 00 | 0 | 0 | C | 0 | 0 | 1.00 |
| 1. 01 | payments DRG amounts other than outlier payments for discharges | 1. 01 | 5, 647, 746 | 0 | 5, 647, 746 | | 5, 647, 746 | 1. 01 |
| 1. 02 | occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October | 1. 02 | 1, 939, 860 | 0 | | 1, 939, 860 | 1, 939, 860 | 1. 02 |
| 1. 03 | DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 | 1. 03 | 0 | 0 | C | | 0 | 1.03 |
| 1. 04 | DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 | 1. 04 | 0 | 0 | | 0 | 0 | 1. 04 |
| 2. 00 | Outlier payments for discharges (see instructions) | 2. 00 | | | | | | 2.00 |
| 2. 01 | Outlier payments for discharges for Model 4 BPCI | 2. 02 | 0 | 0 | | 0 | 0 | |
| 2. 02 | Outlier payments for discharges occurring prior to October 1 (see instructions) | 2. 03 | 24, 941 | 0 | 24, 941 | | 24, 941 | 2.02 |
| 2. 03 | Outlier payments for discharges occurring on or after October 1 (see instructions) | 2. 04 | 536 | 0 | | 536 | 536 | 2.03 |
| 3. 00 | Operating outlier reconciliation | 2. 01 | 0 | 0 | C | 0 | 0 | 3.00 |
| 4. 00 | Managed care simulated payments | 3. 00 | 0 | 0 | C | 0 | 0 | 4.00 |
| 5. 00 | Indirect Medical Education Adj Amount from Worksheet E, Part | ustment 21.00 | 0. 000000 | 0. 000000 | 0. 000000 | 0. 000000 | | 5. 00 |
| 6. 00 | A, line 21 (see instructions) IME payment adjustment (see instructions) | 22. 00 | 0 | 0 | C | 0 | 0 | 6. 00 |
| 6. 01 | IME payment adjustment for managed care (see | 22. 01 | 0 | 0 | C | 0 | 0 | 6. 01 |
| | instructions) | | - A-I-I E C- | 100 1 | | | | |
| 7. 00 | Indirect Medical Education Adj | ustment for the | 0.000000 | 0.000000 | | 0. 000000 | | 7.00 |
| | (see instructions) | | | 0.000000 | 0.000000 | 0.00000 | | |
| 8. 00 8. 01 | IME adjustment (see instructions) | 28. 00 28. 01 | 0 | 0 | | 0 | 0 | |
| 0.01 | IME payment adjustment add on for managed care (see instructions) | 26.01 | U | O | | 0 | 0 | 8.01 |
| 9. 00 | Total IME payment (sum of lines 6 and 8) | 29. 00 | 0 | 0 | С | 0 | 0 | 9. 00 |
| 9. 01 | Total IME payment for managed care (sum of lines 6.01 and 8.01) | 29. 01 | 0 | 0 | C | 0 | 0 | 9. 01 |
| | Disproportionate Share Adjustm | ent | | | <u> </u> | | | 1 |
| 10.00 | Allowable disproportionate share percentage (see | 33. 00 | 0. 0714 | 0. 0714 | 0. 0714 | 0. 0714 | | 10.00 |
| 11. 00 | <pre>instructions) Disproportionate share adjustment (see instructions)</pre> | 34. 00 | 135, 439 | 0 | 100, 812 | 34, 627 | 135, 439 | 11.00 |
| 11. 01 | Uncompensated care payments | 36. 00 | 481, 255 | 0 | 332, 536 | 148, 719 | 481, 255 | 11.01 |
| 12. 00 | Additional payment for high pe Total ESRD additional payment | rcentage of ESI 46.00 | peneticiary 0 | di scharges 0 | С | 0 | 0 | 12.00 |
| 13. 00 14. 00 | (see instructions) Subtotal (see instructions) Hospital specific payments | 47. 00 48. 00 | 8, 229, 777 9, 656, 274 | 0 | | | 8, 229, 777 9, 656, 274 | 13. 00 |
| 15. 00 | (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient | 49. 00 | 9, 299, 650 | 0 | 6, 944, 571 | 2, 355, 079 | 9, 299, 650 | 15. 00 |
| | operating costs (see instructions) | | | | | | | |

| | Titianciai Systems | IIL | INKT COUNTT WEW | ONTAL HOST TIAL | | III LI C | u or rorm cws | 2552-10 |
|------------------|--|-----------------------|-----------------------------|-------------------------|--------------------------|--|--|------------------|
| LOW VO | LUME CALCULATION EXHIBIT 4 | | | Provi der C | CN: 15-0030 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibi Date/Time Pre 5/26/2022 3:4 | pared: |
| | | | | Title | XVIII | Hospi tal | PPS | |
| | | W/S E, Part A line | Amounts (from E, Part A) | Pre/Post Entitlement | Period Prior to 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 | 574, 682 | 0 | | | 574, 682 | 16.00 |
| 17. 00 17. 01 | Special add-on payments for new technologies | 54.00 | 246, 902 | 0 | 180, 11 | 66, 788 | 246, 902 | 17. 00 17. 01 |
| 17. 01 | Net organ aquisition cost Credits received from manufacturers for replaced | 68. 00 | 0 | 0 | | 0 0 | 0 | 1 |
| 18. 00 | devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see | | 0 | 0 | | 0 0 | 0 | 18. 00 |
| 19. 00 | instructions) SUBTOTAL | W/C I Line | (Amounta from | 0 | 7, 555, 77 | 2, 565, 460 | 10, 121, 234 | 19. 00 |
| | | W/S L, line | (Amounts from L) | | 0.00 | | 5.00 | |
| | T | 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 | 571, 417 0 | 0 | 427, 87 | 70 143, 547 0 0 | 571, 417 0 | |
| 21. 00 21. 01 | Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments | 2. 00 2. 01 | 3, 265 0 | 0 | 3, 21 | 9 46 0 | 3, 265 0 | 1 |
| 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 | 0 | 23. 00 |
| 24. 00 | Allowable disproportionate share percentage (see instructions) | 10. 00 | 0. 0000 | 0.0000 | 0.000 | 0. 0000 | | 24.00 |
| 25. 00 | Disproportionate share adjustment (see instructions) | 11. 00 | 0 | 0 | | 0 0 | 0 | 25. 00 |
| 26. 00 | Total prospective capital payments (see instructions) | 12. 00 | 574, 682 | 0 | 431, 08 | 143, 593 | 574, 682 | 26. 00 |
| | | W/S E, Part A | (Amounts to | | | | | |
| | | line | E, Part A) | | | | | |
| | | 0 | 1, 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 27. 00 | Low volume adjustment factor | - | | | 0. 11439 | | | 27. 00 |
| 28. 00 | Low volume adjustment (transfer amount to Wkst. E, | 70. 96 | | | 864, 33 | | 864, 335 | |
| 29. 00 | Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, | 70. 97 | | | | 301, 637 | 301, 637 | 29. 00 |
| 100. 00 | Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A. | | Y | | | | | 100. 00 |

Provider CCN: 15-0030

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 01/01/2021 Part A Exhibit 5 Date/Time Prepared: 5/26/2022 3:43 pm 12/31/2021 Title XVIII Hospi tal Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 5.647.746 5, 647, 746 5.647.746 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 1 02 1, 939, 860 1, 939, 860 1, 939, 860 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1 04 0 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 2.01 **BPCI** 2.02 24, 941 24, 941 24, 941 2.02 Outlier payments for discharges occurring 2.03 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 536 536 2.03 536 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 C 0 0 3.00 Managed care simulated payments 0 4.00 4.00 3.00 Indirect Medical Education Adjustment 0.000000 0.000000 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22.00 0 6.00 0 6.01 IME payment adjustment for managed care (see 22.01 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 0 0 IME payment adjustment add on for managed 0 28 01 C 0 8 01 8 01 0 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 9.00 0 Total IME payment for managed care (sum of 9.01 29.01 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 10.00 Allowable disproportionate share percentage 33.00 0.0714 0.0714 0.0714 (see instructions) 11.00 Di sproporti onate share adjustment (see 34.00 135, 439 100, 812 34, 627 135, 439 11.00 instructions) Uncompensa<u>ted care payments</u> 148, 719 481, 255 11.01 36 00 481, 255 332, 536 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12.00 46.00 12.00 instructions) 8, 229, 777 6, 106, 035 47.00 13.00 Subtotal (see instructions) 2, 123, 742 8, 229, 777 13.00 14.00 Hospital specific payments (completed by SCH 48.00 9, 656, 274 14.00 \cap and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 9, 299, 650 15 00 49 00 7 175 908 2 123 742 9, 299, 650 15 00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 574, 682 431, 089 143, 593 574, 682 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 246, 902 180, 113 66, 789 246, 902 17.00 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for 68.00 0 0 Λ 17.02 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 18.00 amount (see instructions) 19.00 SUBTOTAL 7, 787, 110 2. 334. 124 10, 121, 234 19. 00

| | | ENRY COUNTY MEM | | | | u of Form CMS-2 | <u> 2552-10</u> |
|---------|--|-----------------|------------------------|---------|---|--|-----------------|
| HOSPI T | AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA | ATION EXHIBIT 5 | Provi der CO | | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibi Date/Time Pre 5/26/2022 3:4 | pared: |
| | | | Title | XVIII | Hospi tal | PPS | |
| | | Wkst. L, line | (Amt. from Wkst. L) | | | | |
| | | 0 | 1. 00 | 2. 00 | 3. 00 | 4. 00 | |
| 20.00 | Capital DRG other than outlier | 1. 00 | 571, 417 | 427, 87 | 0 143, 547 | 571, 417 | 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 | 3, 265 | 3, 21 | 9 46 | 3, 265 | 21.00 |
| 21.01 | Model 4 BPCI Capital DRG outlier payments | 2. 01 | 0 | | 0 0 | 0 | 21.01 |
| 22. 00 | Indirect medical education percentage (see instructions) | 5. 00 | 0. 0000 | 0. 000 | 0.0000 | | 22. 00 |
| 23. 00 | Indirect medical education adjustment (see instructions) | 6. 00 | 0 | | 0 0 | 0 | 23. 00 |
| 24. 00 | Allowable disproportionate share percentage (see instructions) | 10. 00 | 0. 0000 | 0. 000 | 0.0000 | | 24.00 |
| 25. 00 | Disproportionate share adjustment (see instructions) | 11. 00 | 0 | | 0 | 0 | 25. 00 |
| 26. 00 | Total prospective capital payments (see instructions) | 12. 00 | 574, 682 | 431, 08 | 9 143, 593 | 574, 682 | 26. 00 |
| | | Wkc+ E D+ | (Amt from | | | | |

| | i nstructi ons) | | | | | | |
|--------|--|--------------|--------------|-----------|----------|--------------|--------|
| | | 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 | 864, 335 | 864, 335 | | 864, 335 | 28.00 |
| 29. 00 | Low volume adjustment on or after October 1 | 70. 97 | 301, 637 | | 301, 637 | 301, 637 | 29.00 |
| 30.00 | HVBP payment adjustment (see instructions) | 70. 93 | 22, 713 | 22, 713 | 0 | 22, 713 | 30.00 |
| 30. 01 | HVBP payment adjustment for HSP bonus | 70. 90 | 3, 119 | 3, 119 | 0 | 3, 119 | 30. 01 |
| | payment (see instructions) | | | | | | |
| 31.00 | HRR adjustment (see instructions) | 70. 94 | -204, 334 | -174, 836 | -29, 498 | -204, 334 | 31.00 |
| 31. 01 | HRR adjustment for HSP bonus payment (see | 70. 91 | -27, 970 | -24, 006 | -3, 964 | -27, 970 | 31.01 |
| | instructions) | | | | | | |
| | | | | | | (Amt. to | |
| | | | | | | Wkst. E, Pt. | |
| | | | | | | A) | |
| | | 0 | 1.00 | 2. 00 | 3. 00 | 4. 00 | |
| 32.00 | HAC Reduction Program adjustment (see | 70. 99 | | 0 | 0 | 0 | 32.00 |
| | instructions) | | | | | | |
| 100.00 | Transfer HAC Reduction Program adjustment to | | N | | | | 100.00 |
| | Wkst. E, Pt. A. | | | | | | |
| | | | | | | | |

| Health Financial Systems | HENRY COUNTY MEMORIAL HOSPITAL | In Lie | u of Form CMS-2552-10 |
|---|--------------------------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0030 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet E Part B Date/Time Prepared: 5/26/2022 3:43 pm |

| | Title Will Head to | 5/26/2022 3: 4 | 3 pm |
|----------------------------|--|--------------------|------------------|
| | Title XVIII Hospital | PPS | |
| | | 1. 00 | |
| | PART B - MEDICAL AND OTHER HEALTH SERVICES | 171 | 1 00 |
| 1. 00 2. 00 | Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions) | 171 9, 436, 358 | 1 |
| 3. 00 | OPPS payments | 9, 095, 842 | 1 |
| 4. 00 | Outlier payment (see instructions) | 9, 026 | 1 |
| 4. 01 | Outlier reconciliation amount (see instructions) | 0 | 4. 01 |
| 5.00 | Enter the hospital specific payment to cost ratio (see instructions) | 0.000 | 1 |
| 6.00 | Line 2 times line 5 | 0 | |
| 7. 00 8. 00 | Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions) | 0.00 | 1 |
| 9. 00 | Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 | | 1 |
| 10. 00 | Organ acqui si ti ons | 0 | |
| 11. 00 | Total cost (sum of lines 1 and 10) (see instructions) | 171 | 11.00 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | 1 |
| 40.00 | Reasonable charges | 440 | 10.00 |
| | Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) | 410 | 12. 00 13. 00 |
| | Total reasonable charges (sum of lines 12 and 13) | | 14.00 |
| 14.00 | Customary charges | 1 410 | 14.00 |
| 15.00 | Aggregate amount actually collected from patients liable for payment for services on a charge basi | s 0 | 15.00 |
| 16.00 | Amounts that would have been realized from patients liable for payment for services on a chargebas | si s 0 | 16.00 |
| | had such payment been made in accordance with 42 CFR §413.13(e) | | |
| | Ratio of line 15 to line 16 (not to exceed 1.000000) | 0.000000 | 1 |
| | Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see | 410 | 1 |
| 17.00 | instructions) | 257 | 17.00 |
| 20.00 | Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see | 0 | 20.00 |
| | instructions) | | |
| | Lesser of cost or charges (see instructions) | 171 | 1 |
| | Interns and residents (see instructions) Cost of physicians' convices in a teaching bespital (see instructions) | 0 | |
| | Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) | 9, 104, 868 | 1 |
| 21.00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT | 7, 101, 000 | 21.00 |
| | Deductibles and coinsurance amounts (for CAH, see instructions) | 0 | 25. 00 |
| | Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) | 1, 476, 653 | 26.00 |
| 27. 00 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see | e 7, 628, 386 | 27.00 |
| 28. 00 | instructions) Direct graduate modical adjustion navments (from Wkst. E. 4. Line 50) | 0 | 28. 00 |
| | Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) | 0 | 1 |
| | Subtotal (sum of lines 27 through 29) | 7, 628, 386 | 1 |
| | Primary payer payments | 1, 909 | 31.00 |
| 32.00 | Subtotal (line 30 minus line 31) | 7, 626, 477 | 32.00 |
| 22.00 | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | 1 22 00 |
| | Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) | 162, 581 | |
| | Adjusted reimbursable bad debts (see instructions) | 105, 678 | |
| | Allowable bad debts for dual eligible beneficiaries (see instructions) | 144, 819 | |
| | Subtotal (see instructions) | 7, 732, 155 | 37.00 |
| | MSP-LCC reconciliation amount from PS&R | 0 | 1 |
| | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | 0 | |
| | Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration | 0 | 39. 50 39. 97 |
| | Partial or full credits received from manufacturers for replaced devices (see instructions) | 0 | 1 |
| | RECOVERY OF ACCELERATED DEPRECIATION | l o | 1 |
| | Subtotal (see instructions) | 7, 732, 155 | 40.00 |
| | Sequestration adjustment (see instructions) | 0 | |
| | Demonstration payment adjustment amount after sequestration | 0 | |
| | Sequestration adjustment-PARHM pass-throughs | 7 000 004 | 40.03 |
| | Interim payments Interim payments-PARHM | 7, 808, 204 | 41.00 |
| | Tentative settlement (for contractors use only) | 0 | 1 |
| | Tentative settlement-PARHM (for contractor use only) | | 42. 01 |
| | Balance due provider/program (see instructions) | -76, 049 | 1 |
| | Balance due provider/program-PARHM (see instructions) | | 43. 01 |
| 44. 00 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, | 0 | 44.00 |
| | §115. 2 TO BE COMPLETED BY CONTRACTOR | | 1 |
| | Original outlier amount (see instructions) | 0 | 90.00 |
| 90.00 | 1 | 1 | |
| | Outlier reconciliation adjustment amount (see instructions) | 0 | |
| 91.00 | Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money | 0.00 | |
| 91. 00 92. 00 93. 00 | · · · · · · · · · · · · · · · · · · · | | 92. 00 93. 00 |

Health Financial Systems HENRY CANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2021 | Part I | Date/Time Prepared: | From 01/01/2021 | Date/Time Prepared: | From 01/01/2021 | Part | Prepared: | Prepare Provi der CCN: 15-0030

| | | | | 0 12/31/2021 | 5/26/2022 3:4 | |
|----------------|--|------------|--------------|--------------|-------------------------|--------|
| | | Title | xVIII | Hospi tal | PPS | о рііі |
| | | Inpatien | nt Part A | Par | t B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1. 00 | 2.00 | 3. 00 | 4. 00 | |
| 1. 00 | Total interim payments paid to provider | 1100 | 10, 126, 566 | | 7, 626, 401 | 1.00 |
| 2.00 | Interim payments payable on individual bills, either | | 0 | | 0 | 2.00 |
| | submitted or to be submitted to the contractor for | | | | | |
| | services rendered in the cost reporting period. If none, | | | | | |
| | write "NONE" or enter a zero | | | | | |
| 3. 00 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate | | | | | 3.00 |
| | for the cost reporting period. Also show date of each | | | | | |
| | payment. If none, write "NONE" or enter a zero. (1) | | | | | |
| | Program to Provider | | 1 | | | |
| 3. 01 | ADJUSTMENTS TO PROVI DER | | C | 12/01/2021 | 181, 803 | 3. 01 |
| 3. 02 | | | |) | 0 | 3. 02 |
| 3.03 | | | 0 | | 0 | 3.03 |
| 3. 04 | | | (| | 0 | 3. 04 |
| 3. 05 | | | |) | 0 | 3.05 |
| 2 50 | Provi der to Program ADJUSTMENTS TO PROGRAM | ı | 1 0 | | 0 | 3. 50 |
| 3. 50 3. 51 | ADJUSTMENTS TO PROGRAM | | | | | 3. 50 |
| 3. 52 | | | | | | 3. 52 |
| 3. 53 | | | | | | 3.53 |
| 3. 54 | | | | | l ol | 3. 54 |
| 3. 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines | | 0 |) | 181, 803 | 3. 99 |
| | 3. 50-3. 98) | | | | | |
| 4.00 | Total interim payments (sum of lines 1, 2, and 3.99) | | 10, 126, 566 | | 7, 808, 204 | 4.00 |
| | (transfer to Wkst. E or Wkst. E-3, line and column as | | | | | |
| | appropriate) TO BE COMPLETED BY CONTRACTOR | | | | | |
| 5. 00 | List separately each tentative settlement payment after | | | | | 5.00 |
| 5. 00 | desk review. Also show date of each payment. If none. | | | | | 3.00 |
| | write "NONE" or enter a zero. (1) | | | | | |
| | Program to Provider | | | | | |
| 5. 01 | TENTATI VE TO PROVI DER | | c | | 0 | 5. 01 |
| 5. 02 | | | C | | 0 | 5. 02 |
| 5. 03 | Durani dan da Duranyan | | |) | 0 | 5.03 |
| 5. 50 | Provider to Program TENTATIVE TO PROGRAM | 1 | | , | 0 | 5.50 |
| 5. 51 | TENTATIVE TO PROGRAW | | | | | 5. 51 |
| 5. 52 | | | | | | 5. 52 |
| 5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines | | | | l ol | 5. 99 |
| | 5. 50-5. 98) | | | | | |
| 6.00 | Determined net settlement amount (balance due) based on | | | | | 6.00 |
| | the cost report. (1) | | | | | |
| 6. 01 | SETTLEMENT TO PROVIDER | | 8, 197 | | 0 | 6. 01 |
| 6. 02 | SETTLEMENT TO PROGRAM | | 10 124 7/2 | 1 | 76, 049 | 6.02 |
| 7. 00 | Total Medicare program liability (see instructions) | | 10, 134, 763 | Contractor | 7, 732, 155 NPR Date | 7. 00 |
| | | | | Number | (Mo/Day/Yr) | |
| | | (| 0 | 1. 00 | 2.00 | |
| 8. 00 | Name of Contractor | | | | | 8. 00 |
| | · | • | | • | | • |

| Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-1 | | | | | |
|--|---|--------------------------|----------------------------------|----------------|----------------|
| | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT | Provi der CCN: 15-0030 | Peri od: | Worksheet E-1 | |
| | | | From 01/01/2021 To 12/31/2021 | | narod: |
| | | | 10 12/31/2021 | 5/26/2022 3: 4 | |
| | | Title XVIII | Hospi tal | PPS | |
| | | | | | |
| | | | | 1. 00 | |
| | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS | | | | 1 |
| | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION | | | | |
| 1.00 | Total hospital discharges as defined in AARA §4102 from Wkst. | | | | 1.00 |
| 2.00 | 2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost | | | | 2.00 |
| 0.00 | reporting periods beginning on or after 10/01/2013, line 32) | | | | |
| 3.00 | | | | | |
| 4.00 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost | | | | | 4.00 |
| E 00 | reporting periods beginning on or after 10/01/2013, line 32) | | | | 5.00 |
| 5. 00 | Total hospital charges from Wkst C, Pt. I, col. 8 line 200 | inc 20 | | | |
| 6. 00 | Total hospital charity care charges from Wkst. S-10, col. 3 I | | Wko+ C 2 D+ I | | 6. 00 7. 00 |
| 7. 00 | CAH only - The reasonable cost incurred for the purchase of cline 168 | certified Hil technology | WKSt. 5-2, Pt. I | | 7.00 |
| 8.00 | Calculation of the HIT incentive payment (see instructions) | | | | 8.00 |
| 9.00 | Sequestration adjustment amount (see instructions) | | | | 9.00 |
| 10.00 | Calculation of the HIT incentive payment after sequestration | (see instructions) | | | 10.00 |
| | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH | | | | |
| 30.00 | 30.00 Initial/interim HIT payment adjustment (see instructions) | | | | |
| | Other Adjustment (specify) | | | | 31.00 |
| 32. 00 | Balance due provider (line 8 (or line 10) minus line 30 and l | ine 31) (see instructio | ns) | | 32.00 |

| Health Financial Systems | HENRY COUNTY MEMORIAL HOSPITAL | In Lieu of Form CMS-2552-10 |
|---|--------------------------------|--|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0030 | Peri od: Worksheet E-3 From 01/01/2021 Part VI I To 12/31/2021 Date/Time Prepared: 5/26/2022 3:43 pm |

| | | - | To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
|------------------|--|-------------------------|---------------|-----------------------------|----------|
| | | Title XIX | Hospi tal | Cost | <u> </u> |
| | | | Inpatient | Outpati ent | |
| | | | 1.00 | 2. 00 | |
| | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE | CES FOR TITLES V OR XI | | | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | | | |
| 1.00 | Inpatient hospital/SNF/NF services | | 660, 791 | | 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) | | 660, 791 | 0 | 4.00 |
| 5.00 | Inpatient primary payer payments | | 0 | | 5.00 |
| 6.00 | Outpatient primary payer payments | | | 0 | 6.00 |
| 7.00 | Subtotal (line 4 less sum of lines 5 and 6) | | 660, 791 | 0 | 7.00 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | |
| | Reasonabl e Charges | | | | |
| 8.00 | Routine service charges | | 662, 558 | | 8. 00 |
| 9. 00 | Ancillary service charges | | 1, 091, 858 | 0 | |
| 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) | | 1, 754, 416 | 0 | 12.00 |
| 40.00 | CUSTOMARY CHARGES | | 1 0 | | |
| 13. 00 | Amount actually collected from patients liable for payment for se | ervices on a charge | 0 | 0 | 13. 00 |
| 14. 00 | basis | nument for condition on | | 0 | 14 00 |
| 14.00 | Amounts that would have been realized from patients liable for pa a charge basis had such payment been made in accordance with 42 C | | 0 | Ü | 14. 00 |
| 15. 00 | Ratio of line 13 to line 14 (not to exceed 1.000000) | ork 9413. 13(e) | 0. 000000 | 0. 000000 | 15.00 |
| 16. 00 | Total customary charges (see instructions) | | 1, 754, 416 | 0.000000 | 16.00 |
| 17. 00 | Excess of customary charges over reasonable cost (complete only i | fline 16 exceeds | 1, 093, 625 | 0 | |
| 17.00 | line 4) (see instructions) | T TITLE TO EXCECUS | 1,075,025 | O | 17.00 |
| 18. 00 | | fline 4 exceeds line | 0 | 0 | 18. 00 |
| | 16) (see instructions) | | | | |
| 19.00 | Interns and Residents (see instructions) | | o | 0 | 19.00 |
| 20.00 | Cost of physicians' services in a teaching hospital (see instruct | tions) | 0 | 0 | 20.00 |
| 21.00 | Cost of covered services (enter the lesser of line 4 or line 16) | | 660, 791 | 0 | 21.00 |
| | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com | npleted for PPS provid | ers. | | |
| | Other than outlier payments | | 0 | 0 | |
| 23.00 | 1 - 1 - 1 - 3 - 1 - 1 | | 0 | 0 | |
| 24. 00 | Program capital payments | | 0 | | 24. 00 |
| 25. 00 | 1 1 3 1 | | 0 | | 25. 00 |
| | Routine and Ancillary service other pass through costs | | 0 | 0 | |
| | Subtotal (sum of lines 22 through 26) | | 0 | 0 | |
| 28. 00 | Customary charges (title V or XIX PPS covered services only) | | 0 | 0 | |
| 29. 00 | | | 660, 791 | 0 | 29. 00 |
| 20.00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | 0 | 20.00 |
| 30. 00 31. 00 | Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) | | 0 | 0 | |
| 31.00 | Deductibles | | 660, 791 | 0 | |
| | Coinsurance | | 0 | 0 | |
| | Allowable bad debts (see instructions) | | | 0 | 34.00 |
| 35. 00 | Utilization review | | 0 | U | 35.00 |
| 36. 00 | | 3) | 660, 791 | 0 | |
| 37. 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | 3) | 000,771 | 0 | |
| | Subtotal (line 36 ± line 37) | | 660, 791 | 0 | |
| 39. 00 | Direct graduate medical education payments (from Wkst. E-4) | | 0 | · · | 39.00 |
| 40.00 | | | 660, 791 | 0 | 40.00 |
| 41.00 | Interim payments | | 761, 667 | 0 | 41.00 |
| 42.00 | Balance due provider/program (line 40 minus line 41) | | -100, 876 | 0 | 42.00 |
| 43.00 | Protested amounts (nonallowable cost report items) in accordance | with CMS Pub 15-2, | 0 | 0 | 43.00 |
| | chapter 1, §115.2 | | | | |
| | | | | | |

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

Provider CCN: 15-0030

Peri od: Worksheet G From 01/01/2021 To 12/31/2021 Date/Time Prepared:

5/26/2022 3:43 pm

General Fund Speci fi c Endowment Plant Fund Purpose Fund Fund 1.00 2.00 4.00 3.00 CURRENT ASSETS 1.00 Cash on hand in banks 15, 687, 064 0 0 0 1.00 0 2.00 Temporary investments 0 0 0 2.00 3 00 Notes receivable 0 0 3 00 0 4.00 Accounts receivable 19, 085, 706 0 4.00 5.00 0 0 0 5.00 Other receivable 0 6.00 Allowances for uncollectible notes and accounts receivable 0 0 6.00 o 1, 213, 011 0 7 00 7 00 0 Inventory 0 8.00 Prepaid expenses 1, 140, 429 0 0 8.00 0 9.00 Other current assets -3, 066, 189 0 9.00 10.00 Due from other funds 84, 220, 564 0 ol 0 10.00 Total current assets (sum of lines 1-10) 118, 280, 585 0 11.00 0 0 11.00 FIXED ASSETS 12.00 Land 46,000 0 0 0 12.00 Land improvements 0 0 13.00 1.514.802 0 13.00 οĺ 14.00 Accumulated depreciation -1, 003, 178 0 14.00 Bui I di ngs o 15.00 39, 705, 260 0 0 15.00 16.00 Accumulated depreciation -31, 297, 081 0 0 0 0 0 16.00 0 17.00 Leasehold improvements 1, 898, 222 17.00 0 0 18 00 Accumulated depreciation -1, 159, 278 0 18 00 Fixed equipment 21, 978, 177 19.00 19.00 0 0 20.00 Accumulated depreciation -12, 848, 383 0 0 0 20.00 0 21.00 Automobiles and trucks 0 21.00 22.00 Accumulated depreciation 0 22.00 23.00 Major movable equipment 40, 255, 413 0 0 0 0 23.00 Accumulated depreciation 0 24.00 -25, 852, 391 0 24.00 0 25.00 Minor equipment depreciable 0 25.00 Accumulated depreciation 0 0 0 0 26.00 26.00 C 27.00 HIT designated Assets 0 0 27.00 C Accumulated depreciation 0 28.00 0 0 28.00 0 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 Total fixed assets (sum of lines 12-29) 30.00 33, 237, 563 0 0 0 30.00 OTHER ASSETS 31 00 31.00 Investments 21, 909, 475 0 0 0 0 32.00 Deposits on Leases 0 0 32.00 0 0 33.00 Due from owners/officers 0 33.00 o 34.00 Other assets 7, 867, 014 0 34.00 0 Total other assets (sum of lines 31-34) 0 0 35.00 29, 776, 489 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 181, 294, 637 0 0 0 36.00 CURRENT LIABILITIES 37 00 4 795 988 0 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 8, 443, 435 0 38.00 Payroll taxes payable 0 0 0 39.00 39.00 40.00 Notes and Loans payable (short term) 1,067,220 0 0 0 40.00 o 0 Deferred income 41 00 41 00 0 42.00 Accelerated payments C 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities 67, 731, 788 ol 44.00 0 0 44.00 0 Total current liabilities (sum of lines 37 thru 44) 45.00 82, 038, 431 0 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 0 0 0 46.00 0 0 47.00 Notes payable 0 47.00 C 48.00 Unsecured Loans 0 0 0 48.00 Other long term liabilities 0 0 49.00 49.00 11,082,399 0 Total long term liabilities (sum of lines 46 thru 49) 11, 082, 399 0 ol 0 50.00 50.00 51.00 Total liabilities (sum of lines 45 and 50) 93, 120, 830 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 88, 173, 807 52.00 0 53.00 Specific purpose fund 53.00 54 00 Donor created - endowment fund balance - restricted 0 54 00 Donor created - endowment fund balance - unrestricted 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion Total fund balances (sum of lines 52 thru 58) 88, 173, 807 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 181, 294, 637 0 0 0 60.00

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

STATEMENT OF CHANGES IN FUND BALANCES
Provider CCN: 15-0030
Form 01/01/2021
To 12/31/2021
Date/Time Prepared:

| | | | | | To | | Date/Time Pro 5/26/2022 3:4 | |
|------------------|--|-----------|-----------------------|----------|-----|-----------|--------------------------------|----------------|
| | | General | Fund | Speci al | Pur | pose Fund | Endowment Fund | |
| | | 1.00 | 2.00 | 2.00 | | 4.00 | F 00 | |
| 1. 00 | Fund balances at beginning of period | 1. 00 | 2. 00 81, 278, 930 | 3. 00 | | 4.00 | 5. 00 | 1.00 |
| 2. 00 | Net income (loss) (from Wkst. G-3, line 29) | | 6, 894, 877 | | | U | | 2.00 |
| 3. 00 | Total (sum of line 1 and line 2) | | 88, 173, 807 | 1 | | 0 | | 3.00 |
| 4. 00 | Additions (credit adjustments) (specify) | 0 | 00, 173, 007 | | 0 | J | C | |
| 5. 00 | radi trons (eredi t daj detinorite) (epeci ry) | Ö | | | 0 | | C | |
| 6. 00 | | o | | | O | | Ċ | |
| 7. 00 | | O | | | 0 | | C | 7. 00 |
| 8.00 | | 0 | | | 0 | | C | 8.00 |
| 9.00 | | 0 | | | 0 | | C | 9.00 |
| 10.00 | Total additions (sum of line 4-9) | | 0 | | | 0 | | 10.00 |
| 11. 00 | Subtotal (line 3 plus line 10) | | 88, 173, 807 | | | 0 | | 11.00 |
| 12.00 | Deductions (debit adjustments) (specify) | 0 | | | 0 | | C | |
| 13.00 | | 0 | | | 0 | | C | |
| 14.00 | | 0 | | | 0 | | C | |
| 15.00 | | 0 | | | 0 | | | |
| 16. 00 17. 00 | | 0 | | | 0 | | | |
| 18. 00 | Total deductions (sum of lines 12-17) | U | 0 | | U | 0 | | 18.00 |
| 19. 00 | Fund balance at end of period per balance | | 88, 173, 807 | | | 0 | | 19.00 |
| | sheet (line 11 minus line 18) | | 00, 170, 007 | | | ŭ. | | 17.00 |
| | | Endowment | PI ant | Fund | | | | |
| | | Fund | | ı | | | | |
| | | 6. 00 | 7. 00 | 8.00 | | | | |
| 1. 00 | Fund balances at beginning of period | 0 | | 0.00 | 0 | | | 1.00 |
| 2.00 | Net income (loss) (from Wkst. G-3, line 29) | | | | | | | 2.00 |
| 3.00 | Total (sum of line 1 and line 2) | 0 | | | 0 | | | 3.00 |
| 4.00 | Additions (credit adjustments) (specify) | | 0 | | | | | 4. 00 |
| 5. 00 | | | 0 | | | | | 5.00 |
| 6.00 | | | 0 | | | | | 6.00 |
| 7.00 | | | 0 | | | | | 7.00 |
| 8. 00 9. 00 | | | 0 | | | | | 8. 00 9. 00 |
| 10.00 | Total additions (sum of line 4-9) | 0 | U | | 0 | | | 10.00 |
| 11. 00 | Subtotal (line 3 plus line 10) | 0 | | | 0 | | | 11.00 |
| 12. 00 | Deductions (debit adjustments) (specify) | Ŭ | 0 | | | | | 12.00 |
| 13. 00 | , (, (, (,), | | 0 | | | | | 13.00 |
| 14.00 | | | 0 | | | | | 14.00 |
| 15.00 | | | 0 | | | | | 15. 00 |
| 16.00 | | | 0 | | | | | 16. 00 |
| 17. 00 | | | 0 | | | | | 17. 00 |
| 18. 00 | | 0 | | | 0 | | | 18.00 |
| 19. 00 | Fund balance at end of period per balance | 0 | | | 0 | | | 19. 00 |
| | sheet (line 11 minus line 18) | l | | I | ١ | | | 1 |

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

| DATE PART PATTERT REVENUES | | | | 10 | 5 12/31/2021 | Date/lime Pre 5/26/2022 3:4 | |
|---|--------|---|------------|--------------|---------------|--------------------------------|--------|
| PART I - PATIENT REVENUES Canceral Inpatient Routine Services 1.00 2.00 3.00 | | Cost Center Description | | I npati ent | Outpati ent | | |
| Command Tripatient Routine Services 14,069,920 1.0 | | | | | | | |
| | | PART I - PATIENT REVENUES | | | | | |
| 2.00 SUBPROVIDER | | General Inpatient Routine Services | | | | | |
| SUBPROVIDER SUBPROVIDER | 1.00 | Hospi tal | | 14, 069, 920 | | 14, 069, 920 | 1.00 |
| 4. 00 SUPPROVIDER | 2.00 | SUBPROVI DER - I PF | | | | | 2.00 |
| Swing bed - SNF | 3.00 | SUBPROVI DER - I RF | | | | | 3.00 |
| Swing bed - NF Color Col | 4.00 | SUBPROVI DER | | | | | 4.00 |
| SKILLED NURSING FACILITY | 5.00 | | | | | 0 | 5.00 |
| NURSING FACILITY | 6.00 | Swing bed - NF | | 0 | | 0 | 6.00 |
| OTHER LONG TERM CARE 7.00 | | | | | | 7.00 |
| 10. 00 Total general inpatient care services (sum of lines 1-9) 14, 069, 920 14, 069, 920 10. 00 14, 069, 920 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 12. 00 13. 0 | 8.00 | | | | | | 8.00 |
| Intensive Care Type Inpatient Hospital Services | 9.00 | OTHER LONG TERM CARE | | | | | 9. 00 |
| 11. 00 INTENSIVE CARE UNIT | 10.00 | | | 14, 069, 920 | | 14, 069, 920 | 10.00 |
| 12 00 COROMARY CARE UNIT | | | | | | | |
| 13.00 BURN INTENSIVE CARE UNIT | | | | 7, 558, 475 | | 7, 558, 475 | |
| 14. 00 SURGICAL INTENSIVE CARE (NITT 14. 00 15. 00 17. 0 | | | | | | | |
| 15.00 OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum of lines 7,558,475 7,558,475 16.00 10.11-15) 10.11-15 10.1 | | | | | | | |
| 1-15 Total intensive care type inpatient hospital services (sum of lines 1, 558, 475 1-15 | | | | | | | |
| 11-15 Total inpatient routine care services (sum of lines 10 and 16) | | | | | | | |
| 17. 00 Total inpatient routine care services (sum of lines 10 and 16) 21, 628, 395 21, 628, 395 18. 00 18. 00 Ancillary services 55, 167, 976 206, 440, 113 261, 608, 089 18. 00 19. 00 Outpatient services 6, 693, 918 48, 301, 966 54, 995, 884 19. 00 19. 00 RURAL HEALTH CLINIC 0 4, 910, 785 4, 910, 785 20. 00 20. 01 RURAL HEALTH CLINIC 11 0 1, 836, 665 19, 214, 658 20. 01 20. 02 RURAL HEALTH CLINIC 11 0 1, 836, 665 1, 836, 665 20. 02 21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 22. 00 AMBULANCE SERVICES 22. 00 23. 00 AMBULANCE SERVICES 23. 00 24. 00 CMHC 24. 00 25. 00 AMBULANCE SERVICES 25. 00 26. 00 OSPICE 3, 869 14, 635, 147 14, 639, 016 27. 00 27. 00 NON-REIMBURSEABLE 3, 869 14, 635, 147 14, 639, 016 27. 00 27. 00 PRO FEES 3, 869 14, 635, 147 14, 639, 016 27. 00 27. 01 PRO FEES 3, 869 14, 635, 147 14, 639, 016 27. 00 28. 00 OSPICE 3, 11ne 1) 28. 00 28. 00 29. 00 AMBULANCE SERVICES 3, 869 14, 635, 147 14, 639, 016 27. 00 29. 00 AMBULANCE SERVICES 3, 869 14, 635, 147 14, 639, 016 27. 00 27. 01 PRO FEES 3, 869 14, 635, 147 14, 639, 016 27. 00 28. 00 OSPICE 3, 11ne 1) 28. 00 392, 509, 977 29. 00 ABOUNT 305, 010, 905 392, 509, 977 29. 00 30. 00 30. 00 30. 00 20. 00 ABOUNT 305, 010, 905 392, 509, 977 29. 00 ABOUNT 305, 010, 905 392, 509, 977 29. 00 30. 00 30. 00 30. 00 20. 00 OSPICE 30. 00 | 16.00 | , | lines | 7, 558, 475 | | 7, 558, 475 | 16.00 |
| 18 00 | | l / | | | | | |
| 19, 00 Outpatient services 6,693,918 48,301,966 54,995,884 19,00 | | , | | | | | |
| 20. 00 RURÂL HEALTH CLINIC 0 4,910,785 4,910,785 20. 00 RURAL HEALTH CLINIC 11 0 19,214,658 19,214,658 20. 00 RURAL HEALTH CLINIC 11 0 1,836,665 1,836,665 20. 02 RURAL HEALTH CLINIC 11 0 1,836,665 1,836,665 20. 02 RURAL HEALTH CLINIC 11 0 1,836,665 1,836,665 20. 02 RURAL HEALTH CLINIC 11 0 1,836,665 1,836,665 20. 02 RURAL HEALTH CLINIC 11 0 1,836,665 1,836,665 20. 02 RURAL HEALTH CLINIC 11 0 0 0 0 0 0 0 RURAL HEALTH CLINIC 11 0 1,836,665 1,836,665 20. 02 RURAL HEALTH CLINIC 11 0 0 0 0 0 0 RURAL HEALTH CLINIC 11 0 0 0 0 0 RURAL HEALTH CLINIC 11 0 0 0 0 0 RURAL HEALTH CLINIC 11 0 0 0 0 RURAL HEALTH CLINIC 11 0 0 0 RURAL HEALTH CLINIC 0 0 0 RURAL HEALTH CLINIC 11 0 0 0 RURAL HEALTH CLINIC 1 0 0 0 0 RURAL HEALTH CLINIC 1 0 0 0 0 RURAL HEALTH CLINIC 1 0 0 | | | | | | | |
| 20. 01 RURAL HEALTH CLINIC II 0 19, 214, 658 19, 214, 658 20. 01 20. 02 RURAL HEALTH CLINIC III 0 1, 836, 665 1, 836, 665 20. 01 20. 02 RURAL HEALTH CLINIC III 0 0 0 0 20. 00 0 0 0 0 20. 00 0 0 0 20. 00 0 0 0 20. 00 0 0 0 20. 00 0 0 0 20. 00 0 0 0 20. 00 0 0 0 20. 00 0 0 20. 00 0 0 20. 00 0 0 20. 00 0 0 20. 00 0 0 20. 00 0 0 20. 00 0 0 20. 00 20. 00 0 20. 00 20. 00 0 20. 00 20. 00 0 20. 00 | | | | | | | |
| 20. 02 RURAL HEALTH CLINIC III 1,836,665 1,836,665 1,836,665 2.0.02 2.1.00 EEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | - | | | |
| 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 21.00 10.00 22.00 10.00 10.00 22.00 10.00 10.00 22.00 10.00 10.00 22.00 10.00 10.00 22.00 10.00 10.00 22.00 10.00 22.00 | | | | - | | | |
| 22.00 HOME HEALTH AGENCY AMBULANCE SERVICES 2, 155, 376 2, 155, 376 22.00 23.00 23.00 24.00 24.00 25.00 | | | | - | 1, 836, 665 | | |
| 23. 00 | | | | 0 | 0 | - | |
| 24. 00 | | | | | 2, 155, 376 | 2, 155, 376 | |
| 25. 00 AMBULATORY SURGICAL CENTER (D. P.) 25. 00 26. 00 40. ON 14. 635, 147 14. 639, 016 27. 00 27. 00 28. 00 | | | | | | | |
| 26. 00 HOSPICE | | | | | | | |
| 27. 00 NON-REIMBURSEABLE 3, 869 14, 635, 147 14, 639, 016 27. 00 27. 01 28. 00 7. 01 28. 00 29. 00 29. 00 29. 00 30. 00 31. 00 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 37. 00 38. 00 37. 00 38. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 43. 00 | | | | | | | |
| 27. 01 PRO FEES Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 87, 499, 072 305, 010, 905 392, 509, 977 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 35. 00 36. 00 36. 00 36. 00 37. 00 36. 00 37. 00 38. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 39 and 36 minus line 42)(transfer 10 and | | | | 0 | | | |
| 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 87, 499, 072 305, 010, 905 392, 509, 977 G-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) ADD (SPECIFY) O 31.00 32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) O Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer column 3 to Wkst. 87, 499, 072 305, 010, 905 392, 509, 977 28.00 392, 652, 272 29.00 30.00 31.00 30.00 31.00 31.00 32.00 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 132, 652, 272 43.00 | | | | | | | |
| G-3, line 1) PART II - OPERATING EXPENSES 29.00 30.00 | | | | | | | |
| PART II - OPERATING EXPENSES 29. 00 | 28. 00 | | to Wkst. | 87, 499, 072 | 305, 010, 905 | 392, 509, 977 | 28. 00 |
| 29.00 30.00 30.00 30.00 31.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (per Wkst. A, column 3, line 200) 132,652,272 0 30.00 31.00 31.00 32.00 32.00 33.00 34.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | | |
| 30.00 ADD (SPECIFY) 30.00 31.00 31.00 32.00 32.00 32.00 33.00 34.00 35.00 35.00 36.00 36.00 37.00 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 132,652,272 43.00 | 00.00 | | | | 400 (50 070 | | 00.00 |
| 31.00 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) 131.00 32.00 32.00 33.00 32.00 33.00 33.00 33.00 33.00 33.00 33.00 34.00 35.00 36.00 37.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 41.00 42.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 132,652,272 43.00 | | | | 0 | 132, 652, 272 | | |
| 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 0 32.00 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) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 132,652,272 43.00 | | ADD (SPECIFY) | | - | | | |
| 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 34.00 34.00 35.00 36.00 37.00 37.00 38.00 39.00 40.00 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) 132,652,272 43.00 | | | | | | | |
| 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 0 34.00 35.00 36.00 37.00 36.00 37.00 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 132,652,272 43.00 | | | | - | | | |
| 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) 0 35.00 36.00 37.00 36.00 37.00 37.00 37.00 37.00 37.00 38.00 0 0 0 0 0 40.00 41.00 42.00 132,652,272 43.00 | | | | - | | | |
| 36.00 Total additions (sum of lines 30-35) 0 36.00 37.00 37.00 37.00 38.00 0 0 38.00 0 0 0 38.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | - | | | |
| 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 0 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 132,652,272 43.00 | | T-1-1 - 18 15 (C 15 00 05) | | 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 132,652,272 43.00 | | | | 0 | U | | |
| 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 132,652,272 43.00 | | 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 132,652,272 43.00 | | | | | | | |
| 42.00 Total deductions (sum of lines 37-41) 0 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 132,652,272 43.00 | | | | | | | |
| 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 132,652,272 43.00 | | T-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1 | | 0 | _ | | |
| | | |) (+ | | ĭ | | |
| to wkst. G-3, line 4) | 43.00 | |)(transfer | | 132, 652, 272 | | 43.00 |
| | | LO WKSL. G-3, TIME 4) | | ļ | ı | | |

| llool +b | LENDY COUNTY MEMODIA | LAL HOCDITAL | مناعا | u of Form CMC (| DEE2 10 |
|----------|--|------------------------|-----------------|----------------------------------|---------|
| | Financial Systems HENRY COUNTY MEMORI ENT OF REVENUES AND EXPENSES | Provider CCN: 15-0030 | Peri od: | u of Form CMS-2 Worksheet G-3 | |
| SIAILW | ENT OF REVENUES AND EXITENSES | 110VI del CCN. 13-0030 | From 01/01/2021 | WOLKSHEET 0-3 | |
| | | | To 12/31/2021 | | |
| | | | | 5/26/2022 3: 4 | 3 pm |
| | | | | 1.00 | |
| 1 00 | Total and the last of the second seco | 00) | | 1.00 | 1 00 |
| 1.00 | Total patient revenues (from Wkst. G-2, Part I, column 3, lir | | | 392, 509, 977 | 1.00 |
| 2.00 | Less contractual allowances and discounts on patients' accour | ITS | | 260, 900, 479 | 2.00 |
| 3.00 | Net patient revenues (line 1 minus line 2) | | 131, 609, 498 | 3.00 | |
| 4.00 | Less total operating expenses (from Wkst. G-2, Part II, line | | 132, 652, 272 | 4.00 | |
| 5. 00 | Net income from service to patients (line 3 minus line 4) | | | -1, 042, 774 | 5. 00 |
| | OTHER I NCOME | | | | , 00 |
| 6.00 | Contributions, donations, bequests, etc | | 0 | 6.00 | |
| 7.00 | Income from investments | | | 1, 128, 374 | |
| 8.00 | Revenues from telephone and other miscellaneous communication | | 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 |
| | Revenue from meals sold to employees and guests | | | 0 | 14.00 |
| | Revenue from rental of living quarters | | | 0 | 15.00 |
| | Revenue from sale of medical and surgical supplies to other t | than patients | | 0 | 16.00 |
| | Revenue from sale of drugs to other than patients | | | 0 | 17.00 |
| | Revenue from sale of medical records and abstracts | | | 0 | 18. 00 |
| 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 OPREATING INCOME | | | 5, 153, 828 | 24.00 |
| 24.01 | NON-OPERATING INCOME | | | 71, 291 | 24. 01 |
| 24. 50 | COVI D-19 PHE Fundi ng | | | 1, 584, 158 | 24.50 |
| 25 00 | Total other income (sum of lines 6.24) | | 7 027 651 | 25 00 | |

7, 937, 651

6, 894, 877

0 27.00 0 28.00 6,894,877 29.00

25.00

26.00

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

| | Financial Systems IS OF HOSPITAL-BASED HOME HEALT | | NRY COUNTY MEMO | ORIAL HOSPITAL Provider CC | | Peri od: | u of Form CMS-2 Worksheet H | 2552-10 |
|------------------|--|---------------------------------|---------------------|--|---------------------------------------|----------------------------------|--------------------------------|------------------|
| | | | | HHA CCN: | | From 01/01/2021 To 12/31/2021 | Date/Time Pre | |
| | | | | | | Home Health | 5/26/2022 3: 4 PPS | 3 pm |
| | | | | | | Agency I | | |
| | | Sal ari es | Benefits | Transportatio n (see instructions) | Contracted/Pi rchased Servi ces | u Other Costs | Total (sum of cols. 1 thru 5) | |
| | | 1. 00 | 2. 00 | 3. 00 | 4.00 | 5. 00 | 6. 00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | | | ol | | 0 | 0 | 1 1 00 |
| 1. 00 | Capital Related - Bldg. & Fixtures | | | ď | | | U | 1.00 |
| 2.00 | Capital Related - Movable | | | o | | 0 | 0 | 2. 00 |
| 3. 00 | Equipment Plant Operation & Maintenance | 0 | 0 | 0 | | 0 | 0 | 3.00 |
| 4.00 | Transportati on | Ö | Ö | Ö | | 0 0 | 0 | 4.00 |
| 5. 00 | Administrative and General HHA REIMBURSABLE SERVICES | 128, 184 | 0 | 74, 594 | | 0 274, 257 | 477, 035 | 5.00 |
| 6. 00 | Skilled Nursing Care | 599, 744 | 0 | 0 | | 0 0 | 599, 744 | 6.00 |
| 7.00 | Physi cal Therapy | 344, 242 | o | o | | 0 0 | 344, 242 | |
| 8. 00 9. 00 | Occupational Therapy Speech Pathology | 35, 548 12, 505 | 0 | 0 | | 0 0 | 35, 548 12, 505 | |
| 10.00 | Medical Social Services | 0 | Ö | Ö | | 0 0 | 0 | 1 |
| 11.00 | Home Heal th Ai de | 25, 578 | O | 0 | | 0 | | 11.00 |
| 12. 00 13. 00 | Supplies (see instructions) Drugs | 0 | ol Ol | ol Ol | | 0 0 | 0 | |
| 14.00 | DME | 0 | O | O | | 0 0 | 0 | 1 |
| 15. 00 | HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services | 0 | ol | ol | | ol ol | 0 | 15. 00 |
| 16. 00 | Respiratory Therapy | 0 | o | o | | 0 0 | 0 | |
| 17.00 | Private Duty Nursing | 0 | o | O | | 0 0 | 0 | |
| 18. 00 19. 00 | Clinic Health Promotion Activities | 0 | 0 | 0 | | 0 0 | 0 | 18. 00 19. 00 |
| 20. 00 | Day Care Program | o o | Ö | Ö | | 0 0 | 0 | 1 |
| 21.00 | Home Delivered Meals Program | 0 | o | 0 | | 0 | 0 | 21.00 |
| 22. 00 23. 00 | Homemaker Service All Others (specify) | 0 | ol Ol | ol Ol | | 0 0 | 0 | 22. 00 23. 00 |
| 23. 50 | Tel emedi ci ne | 0 | o | 0 | | 0 0 | 0 | 23. 50 |
| 24. 00 | Total (sum of lines 1-23) | 1, 145, 801 Recl assi fi cat | Recl assi fi ed | 74,594 Adjustments | Net Expenses | 0 274, 257 | 1, 494, 652 | 24.00 |
| | | i on | Tri al Balance | riaj astilients | for | | | |
| | | | (col. 6 + col.7) | | Allocation (col. 8 + | | | |
| | | | COI . 7) | | col . 9) | | | |
| | CENEDAL CEDIALCE COCT CENTEDO | 7. 00 | 8. 00 | 9. 00 | 10. 00 | | | |
| 1. 00 | GENERAL SERVICE COST CENTERS Capital Related - Bldg. & | 0 | ol | ol | | o | | 1.00 |
| | Fixtures | _ | | | | | | |
| 2. 00 | Capital Related - Movable Equipment | 0 | 0 | 0 | | 0 | | 2.00 |
| 3.00 | Plant Operation & Maintenance | 0 | О | О | | О | | 3. 00 |
| 4. 00 5. 00 | Transportation Administrative and General | 0 14, 445 | 0 491, 480 | 0 -15, 343 | 476, 13 | 0 | | 4. 00 5. 00 |
| 5.00 | HHA REIMBURSABLE SERVICES | 14, 445 | | -10, 343 | 470, 13 | / | | 5.00 |
| 6.00 | Skilled Nursing Care | 0 | 599, 744 | 0 | 599, 74 | | | 6.00 |
| 7. 00 8. 00 | Physical Therapy Occupational Therapy | 0 | 344, 242 35, 548 | 0 | 344, 24 35, 54 | | | 7. 00 8. 00 |
| 9. 00 | Speech Pathology | 0 | 12, 505 | ō | 12, 50 | | | 9. 00 |
| 10. 00 11. 00 | Medical Social Services Home Health Aide | 0 | 0 25, 578 | 0 | 25, 57 | 0 | | 10. 00 11. 00 |
| 12.00 | Supplies (see instructions) | 0 | 25, 576 | 0 | 25, 57 | 0 | | 12.00 |
| 13.00 | Drugs | 0 | O | O | | 0 | | 13.00 |
| 14. 00 | DME HHA NONREI MBURSABLE SERVI CES | 0 | 0 | 0 | | 0 | | 14.00 |
| 15.00 | Home Dialysis Aide Services | 0 | 0 | 0 | | 0 | | 15. 00 |
| 16. 00 17. 00 | Respiratory Therapy Private Duty Nursing | 0 | 0 | 0 | | 0 | | 16. 00 17. 00 |
| | Clinic | 0 | ol | ol | | Ö | | 18.00 |
| 19. 00 | Health Promotion Activities | 0 | 0 | 0 | | 0 | | 19.00 |
| 20. 00 21. 00 | Day Care Program Home Delivered Meals Program | 0 | 0 | 0 | | 0 | | 20. 00 21. 00 |
| 22. 00 | Homemaker Service | 0 | Ö | ő | | Ō | | 22.00 |
| 23. 00 23. 50 | All Others (specify) Telemedicine | 0 | 0 | 0 | | 0 | | 23. 00 23. 50 |
| | Total (sum of lines 1-23) | 14, 445 | 1, 509, 097 | -15, 343 | 1, 493, 75 | 4 | | 24.00 |
| | | | , | ' | | | | - |

| OST A | ALLOCATION - HHA GENERAL SERVICE | COST | | Provider C | CN: 15-0030 15-7430 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet H-1 Part I Date/Time Pre 5/26/2022 3:4 | pared: |
|--|--|---|-----------------------|----------------------|-------------------------------------|--|---|----------------------------|
| | | | | | | Home Health | PPS | <u>o p</u> |
| | | | Capital Rela | ated Costs | | Agency I | | |
| | | Net Expenses for Cost Allocation (from Wkst. | BI dgs & Fi xtures | Movable Equipment | Plant Operation & Maintenance | | Subtotal (col s. 0-4) | |
| | | H, col . 10) 0 | 1. 00 | 2. 00 | 3.00 | 4.00 | 4A. 00 | |
| | GENERAL SERVICE COST CENTERS | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 4A. 00 | |
| . 00 | Capital Related - Bldg. & | 0 | 0 | | | | 0 | 1.00 |
| . 00 | Fixtures Capital Related - Movable Equipment | 0 | | 0 | | | 0 | 2.00 |
| . 00 | Plant Operation & Maintenance | 0 | 0 | 0 | | 0 | 0 | |
| . 00 . 00 | Transportation Administrative and General | 476, 137 | 0 | 0 | | 0 0 | 476, 137 | 4. 00 5. 00 |
| . 55 | HHA REIMBURSABLE SERVICES | 470, 137 | <u> </u> | | | <u> </u> | 470, 137 |] 5.00 |
| . 00 | Skilled Nursing Care | 599, 744 | 0 | 0 | | 0 0 | 599, 744 | |
| . 00 . 00 | Physical Therapy Occupational Therapy | 344, 242 35, 548 | 0 | 0 | • | 0 0 | 344, 242 35, 548 | |
| . 00 | Speech Pathology | 12, 505 | Ö | Ö | | 0 0 | 12, 505 | |
| 0.00 | Medical Social Services | 0 | 0 | 0 | | 0 0 | 0 | |
| 1. 00 2. 00 | Home Health Aide Supplies (see instructions) | 25, 578 0 | 0 | 0 | | | 25, 578 0 | |
| 3. 00 | Drugs | 0 | ő | Ö | • | 0 | 0 | |
| 4. 00 | DME | 0 | 0 | 0 | | 0 0 | 0 | 14.00 |
| 5. 00 | HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services | 0 | 0 | 0 | 1 | ol ol | 0 | 15.00 |
| 6. 00 | Respiratory Therapy | 0 | o | 0 | • | | 0 | 1 |
| 7. 00 | Private Duty Nursing | 0 | O | 0 | | 0 0 | 0 | |
| 8. 00 9. 00 | Clinic | 0 | 0 | 0 | • | 0 0 | 0 | |
| 0.00 | Health Promotion Activities Day Care Program | 0 | 0 | 0 | | | 0 | |
| 1. 00 | Home Delivered Meals Program | 0 | ō | 0 | | 0 0 | 0 | |
| 2.00 | Homemaker Service | 0 | 0 | 0 | | 0 0 | 0 | |
| 3. 00 3. 50 | All Others (specify) Telemedicine | 0 | 0 | 0 | | 0 0 | 0 | |
| | Total (sum of lines 1-23) | 1, 493, 754 | Ö | Ö | l . | 0 0 | 1, 493, 754 | |
| | | Admi ni strati v | , , | | | | | |
| | | e & General 5.00 | 4A + 5) 6.00 | | | | | |
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| . 00 | Capital Related - Bldg. & Fixtures | | | | | | | 1.00 |
| . 00 | Capital Related - Movable | | | | | | | 2.00 |
| | Equi pment | | | | | | | |
| . 00 . 00 | Plant Operation & Maintenance Transportation | | | | | | | 3. 00 4. 00 |
| . 00 | Administrative and General | 476, 137 | | | | | | 5.00 |
| | HHA REIMBURSABLE SERVICES | | | | | | | |
| . 00 . 00 | Skilled Nursing Care Physical Therapy | 280, 616 161, 069 | 880, 360 505, 311 | | | | | 6. 00 7. 00 |
| . 00 | Occupational Therapy | 16, 633 | 52, 181 | | | | | 8.00 |
| . 00 | Speech Pathology | 5, 851 | 18, 356 | | | | | 9. 00 |
| 0.00 | Medical Social Services | 11 0/0 | 0 | | | | | 10.00 |
| 1.00 | Home Health Aide Supplies (see instructions) | 11, 968 0 | 37, 546 0 | | | | | 11. 00 12. 00 |
| 3. 00 | Drugs | 0 | O | | | | | 13.00 |
| 4. 00 | | 0 | 0 | | | | | 14.00 |
| | HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services | 0 | 0 | | | | | 15.00 |
| 5. 00 | Respiratory Therapy | 0 | O | | | | | 16.00 |
| 5. 00 6. 00 | ID D I N | 0 | 0 | | | | | 17.00 |
| 6. 00 7. 00 | | | 0 | | | | | 18.00 |
| 6. 00 7. 00 8. 00 | Clinic | 0 | | | | | | 1 19 00 |
| 6. 00 7. 00 8. 00 9. 00 | | 0 0 0 | 0 | | | | | |
| 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 | Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program | 0 0 0 0 | 0 0 0 | | | | | 19.00 20.00 21.00 |
| 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 | Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service | 0 | 0 0 0 0 | | | | | 20. 00 21. 00 22. 00 |
| 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 | Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program | 0 0 0 0 0 | 0 0 0 | | | | | 20. 00 21. 00 |

| 111 41- | Financial Control | ue | NDV COUNTY MEN | AODLAL HOCDITAL | | la lia | 6 Farm CNC / | 2552 40 |
|----------------|---|---------------|-----------------|---------------------------|----------------|----------------------------------|---|---------|
| COST A | <u>Financial Systems</u> LLOCATION - HHA STATISTICAL BAS | | NRY COUNTY MEN | ORIAL HOSPITAL Provider C | | Period: | u of Form CMS-2 Worksheet H-1 | |
| | | | | HHA CCN: | | From 01/01/2021 To 12/31/2021 | Part II Date/Time Pre 5/26/2022 3:4 | |
| | | | | | | Home Health | PPS | |
| | | Capital Rel | ated Costs | | | Agency I | | |
| | | Capi tai Kei | atca costs | | | | | |
| | | BI dgs & | Movabl e | PI ant | Transportation | Reconciliatio | Administrativ | |
| | | Fi xtures | Equi pment | Operation & | n (MI LEAGE) | n | e & General | |
| | | (SQUARE FEET) | (DOLLAR | Mai ntenance | | | (ACCUM. COST) | |
| | | 1.00 | VALUE) 2. 00 | (SQUARE FEET) | 4.00 | 5A. 00 | 5. 00 | |
| | GENERAL SERVICE COST CENTERS | 1.00 | 2. 00 | 3. 00 | 4.00 | 5A. 00 | 5.00 | |
| 1. 00 | Capital Related - Bldg. & | 0 | | | | 0 | | 1.00 |
| 2. 00 | Capital Related - Movable Equipment | | 0 | | | 0 | | 2. 00 |
| 3. 00 | Plant Operation & Maintenance | 0 | 0 | 0 | | 0 | | 3.00 |
| 4. 00 | Transportation (see | O | 0 | 0 | | 0 | | 4. 00 |
| | instructions) | | | | | | | |
| 5.00 | Administrative and General | 0 | 0 | 0 |) | 0 -476, 137 | 1, 017, 617 | 5.00 |
| | HHA REIMBURSABLE SERVICES | 1 _1 | | T | 1 | | T | |
| 6.00 | Skilled Nursing Care | 0 | 0 | l e | | 0 | | |
| 7. 00 8. 00 | Physical Therapy Occupational Therapy | 0 | 0 | | | 0 0 | 344, 242 35, 548 | |
| 9. 00 | Speech Pathology | | 0 | | | | 12, 505 | |
| | Medical Social Services | | 0 | | | | 12, 303 | |
| | Home Heal th Ai de | l o | 0 | | | o o | 25, 578 | |
| | Supplies (see instructions) | 0 | 0 | 0 |) | 0 | 0 | 1 |
| 13.00 | Drugs | 0 | 0 | 0 |) | 0 | 0 | 13.00 |
| 14.00 | | 0 | 0 | 0 |) | 0 0 | 0 | 14.00 |
| | HHA NONREI MBURSABLE SERVI CES | 1 -1 | | _ | 1 | | 1 | |
| | Home Dialysis Aide Services | 0 | 0 | 1 | | 0 | _ | |
| | Respiratory Therapy Private Duty Nursing | 0 | 0 | - | | 0 | 0 | |
| | Clinic | | 0 | | | | 0 | |
| | Health Promotion Activities | | 0 | | | | 0 | |
| | Day Care Program | | 0 | | | | 0 | 20.00 |
| | Home Delivered Meals Program | | 0 | | | 0 | Ö | 1 |
| | Homemaker Service | 0 | 0 | 0 |) | 0 0 | 0 | 22.00 |
| | All Others (specify) | 0 | 0 | 0 |) | 0 0 | 0 | 23. 00 |
| 23. 50 | Tel emedi ci ne | 0 | 0 | 0 |) | 0 0 | 0 | 23. 50 |
| 24.00 | Total (sum of lines 1-23) | 0 | 0 | 0 |) | -476, 137 | | |
| 25. 00 | Cost To Be Allocated (per | 0 | 0 | 0 | 9 | U | 476, 137 | 25.00 |

0.000000

0.000000

0. 467894 26. 00

0. 000000

0.000000

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

| Health Financial Systems | | | HENRY COUNTY MEN | MORI A | AL HOSPITA | AL | | | In Lieu | u of Form CMS-2552-10 |
|-------------------------------|--------------|--------|------------------|--------|------------|------|---------|-------|------------|-----------------------|
| ALLOCATION OF GENERAL SERVICE | COSTS TO HHA | COST C | CENTERS | | Provi der | CCN: | 15-0030 | Perio | od: | Worksheet H-2 |
| | | | | | | | | From | 01/01/2021 | Part I |
| | | | | | HHA CCN: | | 15-7430 | To | 12/31/2021 | Date/Time Prepared: |
| | | | | | | | | | | 5/26/2022 3:43 pm |
| | | | | | | | | Hor | me Health | PPS |
| | | | | | | | | | | İ |

| | | | | | | Agency I | | |
|--|--|--|---|---|---|---|---|--|
| | | | CAPITAL REL | ATED COSTS | | , igo.io y . | | |
| | Cost Center Description | HHA Trial Balance (1) | NEW BLDG & FIXT | NEW MVBLE EQUIP | EMPLOYEE BENEFITS DEPARTMENT | Subtotal | ADMINISTRATIV E & GENERAL | |
| | | 0 | 1. 00 | 2. 00 | 4. 00 | 4A | 5. 00 | |
| 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) | 0 880, 360 505, 311 52, 181 18, 356 0 37, 546 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 | | 4.00 371, 781 0 0 0 0 0 0 0 0 0 0 0 0 0 | 4A 371, 781 880, 360 505, 311 52, 181 18, 356 0 37, 546 0 0 0 0 0 0 0 0 0 0 0 0 0 | 67, 001 158, 656 91, 066 9, 404 3, 308 0 | 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 |
| 19. 50 20. 00 21. 00 | Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description | 0 1, 493, 754 OPERATION OF PLANT | O O LAUNDRY & LI NEN SERVICE | HOUSEKEEPI NG | 0 371, 781 DI ETARY | 0 1, 865, 535 0. 000000 CAFETERI A | NURSI NG ADMI NI STRATI O | 19. 50 20. 00 21. 00 |
| | | 7. 00 | 8. 00 | 9. 00 | 10.00 | 11. 00 | N 13. 00 | |
| 1. 00 2. 00 3. 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 19. 00 21. 00 | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 10 nonded to 6 decimal places. | 63, 487 63, 487 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 13, 576 0 0 0 0 0 0 0 0 0 0 | 000000000000000000000000000000000000000 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 | |

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

| Heal th F | inancial Systems | HE | NRY COUNTY MEMO | ORIAL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--|--|---|--|---|--|--|---|---|
| ALLOCATI | ON OF GENERAL SERVICE COSTS | TO HHA COST CEN | TERS | Provider CC | N: 15-0030 15-7430 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet H-2 Part I Date/Time Pre | |
| | | | | | | Home Health | 5/26/2022 3: 4 PPS | 3 pm |
| | Cost Center Description | CENTRAL SERVI CES & SUPPLY | PHARMACY | MEDI CAL RECORDS & LI BRARY | Subtotal | Agency I Intern & Residents Cost & Post Stepdown Adjustments | Subtotal | |
| | | 14. 00 | 15. 00 | 16. 00 | 24. 00 | 25. 00 | 26. 00 | |
| 2. 00 S 3. 00 P 4. 00 0 5. 00 S 6. 00 M 7. 00 H 8. 00 S 9. 00 D 11. 00 D 11. 00 H 12. 00 R 13. 00 P 14. 00 C 15. 00 H 16. 00 D 17. 00 H 18. 00 C 19. 00 D 19. Idministrative and General Skilled Nursing Care Physical Therapy Decupational Therapy Decupational Therapy Decupational Therapy Decupational Therapy Decupational Therapy Decupational Services December Feathology Decupational Services December See instructions Decupational Services December Dialysis Aide Services December Dialysis Aide Services December Dialysis Aide Services December Dec | 3, 591 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 000000000000000000000000000000000000000 | 3, 167 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 522, 6 1, 039, 0 596, 3 61, 5 21, 6 44, 3 | 033 | 522, 603 1, 039, 016 596, 377 61, 585 21, 664 0 44, 312 0 0 0 0 0 0 0 0 0 0 0 0 0 | 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 |
| | Cost Center Description | Allocated HHA A&G (see Part II) 27.00 | Total HHA Costs | | | | | |
| 1. 00 A | dministrative and General | 27.00 | 28. 00 | | | | | 1.00 |
| 2.00 S 3.00 P 4.00 O 5.00 M 7.00 H 8.00 S 9.00 D 10.00 D 11.00 R 12.00 R 13.00 P 14.00 C 15.00 H 16.00 D 17.00 H 18.00 H 19.00 A 19.50 T 20.00 T 21.00 U | idministrative and General idministrative and General idministrative and General idministrative and General idministrative and General idministrative and General idministrative and General idministrative and General idministrational idministration in the content of the conten | 308, 001 176, 788 18, 256 6, 422 0 13, 136 0 0 0 0 0 0 0 0 0 0 0 0 522, 603 0. 296436 | 1, 347, 017 773, 165 79, 841 28, 086 0 57, 448 0 0 0 0 0 0 0 0 0 0 0 2, 285, 557 | | | | | 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 |

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

BASIS HHA CCN: 15-7430 Home Health

| | | | | | Home Health | PPS | |
|--|---|--|---|---|--|--|---|
| | CAPITAL REL | ATED COSTS | | | Agency I | | |
| Cost Center Description | NEW BLDG & FIXT (SQUARE FEET) | NEW MVBLE EQUIP (SQUARE FEET) | EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) | Reconciliatio n | ADMINISTRATIV E & GENERAL (ACCUM. COST) | OPERATION OF PLANT (SQUARE FEET) | |
| | 1. 00 | 2. 00 | 4. 00 | 5A | 5. 00 | 7. 00 | |
| 1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier Cost Center Description | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 1, 172, 987 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 000000000000000000000000000000000000000 | 371, 781 880, 360 505, 311 52, 181 18, 356 0 37, 546 0 0 0 0 0 0 | 2, 290 0 0 0 0 0 0 0 0 0 0 0 0 0 | 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00 22. 00 |
| | LAUNDRY) | | | | (DI RECT NRSI NG HRS) | (COSTED REQUIS.) | |
| | 8. 00 | 9. 00 | 10. 00 | 11.00 | 13. 00 | 14.00 | |
| 1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2, 290 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 000000000000000000000000000000000000000 | 0 0 0 0 0 0 0 0 0 0 0 0 0 | 26, 565 0 0 0 0 0 0 0 0 0 0 0 0 0 | 21.00 |

| Heal th | Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 | | | | | | | | | |
|----------------|---|----------------|------------------|----------------|---------|-----------------|--------------------------------|----------------|--|--|
| ALLOCA | TION OF GENERAL SERVICE COSTS T | O HHA COST CEN | TERS STATISTICAL | Provi der CCN: | 15-0030 | Peri od: | Worksheet H-2 | | | |
| BASIS | | | | | 45 7400 | From 01/01/2021 | Part II | | | |
| | | | | HHA CCN: | 15-7430 | To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | | | |
| | | | | | | Home Health | PPS | 5 рііі | | |
| | | | | | | Agency I | | | | |
| | Cost Center Description | PHARMACY | MEDI CAL | | | | | | | |
| | | (COSTED | RECORDS & | | | | | | | |
| | | REQUIS.) | LI BRARY | | | | | | | |
| | | | (TIME | | | | | | | |
| | | | SPENT) | | | | | | | |
| 4 00 | | 15. 00 | 16. 00 | | | | | 1 00 | | |
| 1.00 | Administrative and General | 0 | 5 | | | | | 1.00 | | |
| 2.00 | Skilled Nursing Care | 0 | 0 | | | | | 2.00 | | |
| 3.00 | Physical Therapy | 0 | 0 | | | | | 3.00 | | |
| 4.00 | Occupational Therapy | 0 | 0 | | | | | 4.00 | | |
| 5. 00 6. 00 | Speech Pathology Medical Social Services | 0 | 0 | | | | | 5.00 | | |
| 7. 00 | Home Health Aide | 0 | 0 | | | | | 6. 00 7. 00 | | |
| 8. 00 | Supplies (see instructions) | 0 | 0 | | | | | 8.00 | | |
| 9. 00 | Drugs | 0 | 0 | | | | | 9.00 | | |
| 10.00 | DME | 0 | 0 | | | | | 10.00 | | |
| 11. 00 | Home Dialysis Aide Services | 0 | 0 | | | | | 11.00 | | |
| 12. 00 | Respiratory Therapy | 0 | 0 | | | | | 12.00 | | |
| 13. 00 | Private Duty Nursing | 0 | o | | | | | 13.00 | | |
| 14. 00 | Clinic | o | ō | | | | | 14.00 | | |
| 15. 00 | Health Promotion Activities | 0 | o | | | | | 15.00 | | |
| 16.00 | Day Care Program | 0 | o | | | | | 16.00 | | |
| 17.00 | Home Delivered Meals Program | 0 | o | | | | | 17.00 | | |
| 18.00 | Homemaker Service | 0 | o | | | | | 18.00 | | |
| 19.00 | All Others (specify) | 0 | О | | | | | 19.00 | | |
| 19. 50 | Tel emedi ci ne | 0 | o | | | | | 19. 50 | | |
| 20.00 | Total (sum of lines 1-19) | 0 | 5 | | | | | 20.00 | | |
| 21.00 | Total cost to be allocated | 0 | 3, 167 | | | | | 21.00 | | |
| 22. 00 | Unit cost multiplier | 0. 000000 | 633. 400000 | | | | | 22. 00 | | |
| | | | | | | | | | | |

| Heal th | Financial Systems | HE | ENRY COUNTY MEM | ORIAL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|------------------|--|--|-------------------|------------------------------|-------------------------------------|--|--|------------------|
| APPORT | IONMENT OF PATIENT SERVICE COST | ΓS | | Provider C | CN: 15-0030 15-7430 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet H-3 Part I Date/Time Pre | pared: |
| | | | | Title | e XVIII | Home Health Agency I | 5/26/2022 3: 4 PPS | 3 pm |
| | Cost Center Description | From, Wkst. H-2, Part I, col. 28, line | | Shared Ancillary Costs (from | Total HHA Costs (cols. 1 + 2) | Total Visits | Average Cost Per Visit (col. 3 ÷ | |
| | | 0 | Part I) 1.00 | Part II) 2.00 | 3.00 | 4.00 | col . 4) 5.00 | |
| | PART I - COMPUTATION OF LESSER | OF AGGREGATE | PROGRAM COST, A | AGGREGATE OF T | | MITATION COST, (| R BENEFICIARY | |
| | COST LIMITATION Cost Per Visit Computation | | | | | | | |
| 1.00 | Skilled Nursing Care | 2.00 | 1, 347, 017 | | 1, 347, 01 | 7 4, 232 | 318. 29 | 1.00 |
| 2.00 | Physical Therapy | 3.00 | · · | | | | 293. 31 | 2.00 |
| 3. 00 4. 00 | Occupational Therapy Speech Pathology | 4. 00 5. 00 | | 0 | 1 | | 99. 18 178. 89 | |
| 5. 00 | Medical Social Services | 6.00 | | | 20,00 | 0 0 | 0.00 | ı |
| 6. 00 | Home Health Aide | 7. 00 | 1 | | 57, 44 | · | 30. 80 | 1 |
| 7. 00 | Total (sum of lines 1-6) | | 2, 285, 557 | 0 | | | | 7.00 |
| | | | | | Program Visit | .5 | | |
| | | | | | | art B | | |
| | Cost Center Description | Cost Limits | CBSA No. (1) | Part A | Not Subject to | Subject to Deductibles | | |
| | | | | | Deducti bl es | | | |
| | | | 1.00 | 0.00 | Coi nsurance | | 5.00 | |
| | Limitation Cost Computation | 0 | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| 8. 00 | Skilled Nursing Care | | 17140 | О | | 3 | | 8.00 |
| 8. 01 | Skilled Nursing Care | | 34620 | 0 | | 36 | | 8. 01 |
| 8. 02 | Skilled Nursing Care | | 99915 17140 | 0 | 1 | | | 8. 02 9. 00 |
| 9. 00 9. 01 | Physical Therapy Physical Therapy | | 34620 | 0 | 1 | 6 74 | | 9.00 |
| 9. 02 | Physical Therapy | | 99915 | 0 | 1 | | | 9. 02 |
| 10.00 | Occupational Therapy | | 17140 | 0 | | 0 | | 10.00 |
| 10. 01 | Occupational Therapy | | 34620 99915 | 0 | l . | 7 | | 10.01 |
| 10. 02 11. 00 | Occupational Therapy Speech Pathology | | 17140 | 0 | 22 | 0 | | 10. 02 11. 00 |
| 11. 01 | Speech Pathology | | 34620 | 0 | 3 | 32 | | 11. 01 |
| 11. 02 | 1 93 | | 99915 | 0 | 11 | | | 11. 02 |
| 12.00 | Medical Social Services | | 17140 | 0 | | 0 | | 12.00 |
| 12. 01 12. 02 | Medical Social Services Medical Social Services | | 34620 99915 | | | 0 | | 12. 01 12. 02 |
| 13. 00 | Home Heal th Aide | | 17140 | 0 | 1 | 0 | | 13.00 |
| 13. 01 | Home Health Aide | | 34620 | 0 | | 4 | | 13. 01 |
| 13. 02 | Home Heal th Ai de | | 99915 | 0 | 1 | | | 13.02 |
| 14.00 | Total (sum of lines 8-13) Cost Center Description | From Wkst. | Facility | Shared | 3,96 Total HHA | | Ratio (col. 3 | 14.00 |
| | oost center bescriptren | H-2 Part I, | Costs (from | Ancillary | Costs (cols. | 9 | | |
| | | col. 28, line | | Costs (from | 1 + 2) | Records) | | |
| | | 0 | Part I) 1.00 | Part II) 2.00 | 3.00 | 4.00 | 5. 00 | |
| | Supplies and Drugs Cost Comput | | | | | | | |
| | Cost of Medical Supplies | 8. 00 9. 00 | | | 1 | 0 0 | | |
| 16.00 | Cost of Drugs | 9.00 | Program Visits | | Cost of | 0 0 | 0. 000000 | 16.00 |
| | | | | | Servi ces | | | |
| | | | Par | | | Part B | | |
| | Cost Center Description | Part A | Not Subject to | Subject to Deductibles & | Part A | Not Subject to | Subject to Deductibles & | |
| | | | Deductibles & | Coinsurance | | Deductibles & | Coi nsurance | |
| | | | Coi nsurance | | | Coi nsurance | | |
| | PART I - COMPUTATION OF LESSER | 0.00 | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | |
| | COST LIMITATION | - AGGILLOATE | | TOOKEONTE OF T | | | DENET TOTALL | |
| | Cost Per Visit Computation | | | | 1 | | | |
| 1. 00 2. 00 | Skilled Nursing Care Physical Therapy | 0 | | | | 0 411, 231 0 488, 361 | | 1.00 2.00 |
| 3. 00 | Occupational Therapy | 0 | 234 | | | 0 488, 361 | | 3.00 |
| 4.00 | Speech Pathology | 0 | 143 | | | 0 25, 581 | | 4.00 |
| 5.00 | Medical Social Services | 0 | 0 | | | 0 0 | | 5.00 |
| 6. 00 7. 00 | Home Health Aide Total (sum of lines 1-6) | 0 | 628 3, 962 | | | 0 19, 342 0 967, 723 | | 6. 00 7. 00 |
| , . 50 | 1.0101 (30m 01 111103 1 0) | 1 | 3, 702 | | I | 707,723 | | , ,. 00 |

| | Financial Systems FIONMENT OF PATIENT SERVICE COS | | NRY COUNTY MEM | Provider CO | | In Lie Period: From 01/01/2021 To 12/31/2021 Home Health | | Bepared: |
|--|---|---|--|--|---------------------|--|--|--|
| | | | | | | Agency I | | |
| | Cost Center Description | 6. 00 | 7. 00 | 8. 00 | 9.00 | 10.00 | 11.00 | |
| | Limitation Cost Computation | 0.00 | 71.00 | 0.00 | ,,,,,, | 10.00 | | |
| 8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00 | Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide | Progr | cam Covered Ch | D.F. TOS | Cost of | | | 8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 02 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00 |
| | | Progr | ram Covered Cha | arges | Cost of Services | | | |
| | Cost Center Description | Part A | Par Not Subject to Deductibles & Coinsurance | t B Subject to Deductibles & Coinsurance | Part A | Part B Not Subject to Deductibles & Coinsurance | Subject to Deductibles & Coinsurance | |
| | | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10. 00 | 11. 00 | |
| 15. 00 | Supplies and Drugs Cost Comput Cost of Medical Supplies | 0 | 1, 784 | 0 | | 0 0 | | 15.00 |
| 16. 00 | Cost of Drugs Cost Center Description | Total Program Cost (sum of cols. 9-10) 12.00 | 0 | | | 0 | | 16.00 |
| | PART I - COMPUTATION OF LESSER COST LIMITATION | OF AGGREGATE I | PROGRAM COST, | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, (| OR BENEFICIARY | |
| | Cost Per Visit Computation | | | | | | | 1 |
| 1.00 | Skilled Nursing Care | 411, 231 | | | | | | 1.00 |
| 2. 00 3. 00 | Physical Therapy Occupational Therapy | 488, 361 23, 208 | | | | | | 2. 00 3. 00 |
| 4. 00 | Speech Pathology | 25, 206 25, 581 | | | | | | 4.00 |
| 5. 00 | Medical Social Services | 0 | | | | | | 5. 00 |
| 6.00 | Home Health Aide | 19, 342 | | | | | | 6. 00 |
| 7. 00 | Total (sum of lines 1-6) | 967, 723 | | | | | | 7. 00 |
| | Cost Center Description | 12. 00 | | | | | | |
| | Limitation Cost Computation | 72.00 | | | | | | |
| 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 | Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide | | | | | | | 8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00 |

| Heal th | Financial Systems | HE | NRY COUNTY MEM | MORIAL HOSPITAL In Lieu of For | | | | 2552-10 |
|---------|---------------------------------|----------------|-----------------|--------------------------------|---------------|----------------------------------|---|---------|
| APP0R1 | TIONMENT OF PATIENT SERVICE COS | ΓS | | Provi der C | | Peri od: | Worksheet H-3 | |
| | | | | HHA CCN: | 15-7430 | From 01/01/2021 To 12/31/2021 | Part II Date/Time Pre 5/26/2022 3:4 | |
| | | | | Ti tl e | XVIII | Home Health | PPS | |
| | | | | | | Agency I | | |
| | Cost Center Description | From Wkst. C, | Cost to | Total HHA | HHA Shared | Transfer to | | |
| | | Part I, col. | Charge Ratio | Charge (from | Ancillary | Part I as | | |
| | | 9, line | | provi der | Costs (col. | 1 Indicated | | |
| | | | | records) | x col. 2) | | | |
| | | 0 | 1. 00 | 2. 00 | 3. 00 | 4. 00 | | |
| | PART II - APPORTIONMENT OF COS | T OF HHA SERVI | CES FURNISHED E | BY SHARED HOSP | ITAL DEPARTME | NTS | | |
| 1.00 | Physi cal Therapy | 66.00 | 0. 648610 | C | | 0 col. 2, line 2 | . 00 | 1.00 |
| 2.00 | Occupational Therapy | 67.00 | 0. 472713 | C | | 0 col. 2, line 3 | . 00 | 2.00 |
| 3.00 | Speech Pathology | 68.00 | 0. 482605 | C | | 0 col. 2, line 4 | . 00 | 3.00 |
| 4.00 | Cost of Medical Supplies | 71.00 | 0. 126832 | C |) | 0 col. 2, line 1 | 5. 00 | 4.00 |
| 5.00 | Cost of Drugs | 73.00 | 0. 416073 | l c | 1 | 0 col. 2, line 1 | 6. 00 | 5.00 |

| I CHI A | Financial Systems HENRY COUNTY MEMORI ATION OF HHA REIMBURSEMENT SETTLEMENT | | | | In Lieu of Form CMS-2552- Period: Worksheet H-4 | | |
|--|--|---------------------------------|---------|-----|--|---|--|
| LCOL | ATTOW OF THE RETWINDORSEMENT SETTLEMENT | HHA CCN: | 15-7430 | | om 01/01/2021 | Part I-II Date/Time Pre | par |
| | | Title | XVIII | | Home Health Agency I | 5/26/2022 3: 4 PPS | з рі |
| | | | | | | t B | |
| | | | Part A | | Not Subject to Deductibles & | Subject to Deductibles & Coinsurance | |
| | | | | | Coi nsurance | | |
| Т | DADT I COMPUTATION OF THE LECCED OF DEACONABLE COST OF CHICA | COMADY CHARCE | 1.00 | | 2. 00 | 3. 00 | |
| | PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST Reasonable Cost of Part A & Part B Services | UMARY CHARGE | 13 | | | | |
| | Reasonable cost of services (see instructions) | | | 0 | 0 | 0 | 1 |
| 00 [| Total charges | | | 0 | 0 | 0 | 2 |
| | Customary Charges | | | _ | | | _ |
| 00 | Amount actually collected from patients liable for payment for | or services | | 0 | 0 | 0 | 3 |
| | on a charge basis (from your records) Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in | | | 0 | 0 | 0 | 4 |
| | with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000) | | 0. 0000 | 200 | 0. 000000 | 0. 000000 | Ę |
| | Total customary charges (see instructions) | | 0.0000 | 000 | 0.000000 | 0.000000 | 6 |
| 00 | Excess of total customary charges over total reasonable cost only if line 6 exceeds line 1) | ` ' | | 0 | 0 | 0 | - |
| | Excess of reasonable cost over customary charges (complete on 1 exceeds line 6) | nly if line | | 0 | 0 | 0 | 8 |
| 00 | Primary payer amounts | | | U | Part A | Part B | Ç |
| | | | | | Servi ces | Servi ces | |
| | | | | | 1. 00 | 2. 00 | |
| - + | PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions) | | | | O | 0 | 10 |
| - 1 | Total PPS Reimbursement - Full Episodes without Outliers | | | | 0 | 488, 708 | |
| | Total PPS Reimbursement - Full Episodes with Outliers | | | | 0 | 43, 719 | |
| 00 | Total PPS Reimbursement - LUPA Episodes | | | | 0 | 2, 904 | 13 |
| | Total PPS Reimbursement - PEP Episodes | | | | 0 | 0 | 14 |
| | Total PPS Outlier Reimbursement - Full Episodes with Outliers | 5 | | | 0 | 13, 970 | |
| | Total PPS Outlier Reimbursement - PEP Episodes | | | | 0 | 0 | 10 |
| | Total Other Payments DME Payments | | | | 0 | 0 | 13 |
| | Oxygen Payments | | | | 0 | 0 | 10 |
| | Prosthetic and Orthotic Payments | | | | 0 | 0 | 20 |
| | Part B deductibles billed to Medicare patients (exclude coins | surance) | | | | 0 | 2 |
| 00 | Subtotal (sum of lines 10 thru 20 minus line 21) | | | | 0 | 549, 301 | |
| 00 00 | | | | | 0 | 0 E40 201 | 23 |
| 00 00 00 | Excess reasonable cost (from line 8) | | | | 0 | 549, 301 0 | 24 |
| 00 00 00 00 | Subtotal (line 22 minus line 23) | | | | | | _ Z: |
| 00 00 00 00 00 | Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) | | | | 0 | | |
| 00 00 00 00 00 00 | Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) | | | | 0 | 549, 301 | 26 |
| 00 00 00 00 00 00 00 | Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) | nstructions) |) | | 0 0 0 | | 2 <i>6</i> |
| 00 00 00 00 00 00 00 00 | Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) | |) | | 0 | 549, 301 0 | 26 27 28 |
| 00 00 00 00 00 00 00 00 00 00 | Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER | ne 27) |) | | 0 0 0 | 549, 301 0 0 549, 301 1 | 26 27 28 29 30 |
| 00 00 00 00 00 00 00 00 00 00 00 | Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER Pioneer ACO demonstration payment adjustment (see instruction | ne 27) |) | | 0 0 0 0 | 549, 301 0 0 549, 301 1 0 | 26 27 28 29 30 30 |
| 00 00 00 00 00 00 00 00 00 00 50 | Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment before sequestration | ne 27) |) | | 0 0 0 0 0 | 549, 301 0 0 549, 301 1 0 0 | 26 27 28 29 30 30 30 |
| . 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00 | Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) | ne 27) |) | | 0 0 0 0 0 | 549, 301 0 0 549, 301 1 0 0 549, 302 | 26 27 28 29 30 30 30 31 |
| . 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00 | Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) | ne 27) |) | | 0 0 0 0 0 | 549, 301 0 0 549, 301 1 0 0 | 26 27 28 29 30 30 31 31 |
| . 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00 | Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) | ne 27) |) | | 0 0 0 0 0 0 | 549, 301 0 0 549, 301 1 0 0 549, 302 | 26 27 28 29 30 30 31 31 |
| . 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00 | Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration payment adjustment amount after sequestration | ne 27) |) | | 0 0 0 0 0 0 | 549, 301 0 0 549, 301 1 0 0 549, 302 0 | 26 27 28 30 30 31 31 31 |
| . 00 . 00 | Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus line OTHER Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment for non-claims based amounts (see in Interim payments (see instructions) Tentative settlement (for contractor use only) | ne 27) ns) nstructions) |) | | 0 0 0 0 0 0 0 | 549, 301 0 0 549, 301 1 0 0 549, 302 0 0 549, 302 | 26 27 28 29 30 30 31 31 31 31 32 33 |
| . 00 . 00 | Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment for non-claims based amounts (see in Interim payments (see instructions) | ne 27) as) astructions) and 33) | | | 0 0 0 0 0 0 0 | 549, 301 0 549, 301 1 0 549, 302 0 0 0 549, 302 | 26 27 28 29 30 30 31 31 31 31 |

Health Financial Systems HENRY COUNTY MEMOANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED HENRY COUNTY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-0030

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 3:43 pm PPS TO PROGRAM BENEFICIARIES HHA CCN: 15-7430

| Inpatient Part A Part B | | | | | | 5/26/2022 3: 4 | <u>3 pm</u> |
|--|-------|---|------------|-----------|-------------|----------------|-------------|
| Inpatient Part A | | | | | Home Health | PPS | |
| 1.00 | | | | | | | |
| 1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 5.49,302 1.00 1.100 1.100 1.100 5.49,302 1.00 5.49,302 1.00 1.100 1.100 1.100 1.100 5.49,302 1.00 1.00 5.49,302 1.00 1.0 | | | Inpatien | it Part A | Pai | rt B | |
| 1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 5.49,302 1.00 1.100 1.100 1.100 5.49,302 1.00 5.49,302 1.00 1.100 1.100 1.100 1.100 5.49,302 1.00 1.00 5.49,302 1.00 1.0 | | | | | | | |
| 1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 5.49,302 1.00 1.100 1.100 1.100 5.49,302 1.00 5.49,302 1.00 1.100 1.100 1.100 1.100 5.49,302 1.00 1.00 5.49,302 1.00 1.0 | | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| Total interim payments paid to provider 0 | | | | 2.00 | | 4.00 | |
| Interfim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "MONE" or netre a zero | 1 00 | Total interim payments paid to provider | | | _ | | 1 00 |
| Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero | | | | | | 1 | |
| Services rendered in the cost reporting period. If none, write "NONE" or enter a zero the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | 2.00 | | | | ٩ | | 2.00 |
| ### WORLE OF enter a zero **NOLE OF COMPACTOR** **Provider to Program** **Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.99) **O **O **O **O **O **O **O **O **O ** | | | | | | | |
| List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0 | | | | | | | |
| amount based on subsequent revision of the Interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.52 3.53 3.54 3.99 3.50 3.54 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wist. H-4, Part II, column as appropriate, line 32) To BE COMPLETE BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.00 Provider to Program 5.00 Determined new settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROVIDER 5.01 SETILEMENT TO PROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0.00 | | | | | | 0.00 |
| For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0 | 3.00 | | | | | | 3.00 |
| Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider NONE" or enter a zero. (1) Program to Provider NONE" or enter a zero. (1) O | | | | | | | |
| Program to Provider | | for the cost reporting period. Also show date of each | | | | | |
| 3.01 3.02 3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wist. H-4, Part II, column as appropriate, line 32) To BE COMPLETED BY CONTRACTOR write "NoNE" or enter a zero. (1) Program to Provider 5.01 5.01 5.02 5.03 Provider to Program 5.00 5.01 5.02 5.03 Provider to Program 6.00 Certain the state of the | | | | | | | |
| 3.02 3.03 3.04 3.05 Provider to Program Provider to Program State of the program of the progra | | Program to Provider | | | | | |
| 3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32). TO BE COMPLETED BY CONTRACTOR To BE COMPLETED BY CONTRACTOR To BE COMPLETE OBY CONTRACTOR TO C | 3. 01 | | | | 0 | 0 | 3. 01 |
| 3.04 0 0 0 3.04 3.05 3.06 0 0 0 3.06 3.06 3.06 3.06 0 0 0 3.06 | 3.02 | | | | 0 | 0 | 3.02 |
| 3.05 | 3.03 | | | | 0 | 0 | 3.03 |
| Provider to Program | 3.04 | | | | 0 | 0 | 3.04 |
| 3.50 0 0 3.50 3.51 3.52 0 0 0 3.52 3.53 3.52 3.53 0 0 0 3.53 3.53 3.50 3.5 | 3.05 | | | | 0 | 0 | 3.05 |
| 3.51 0 | | Provider to Program | | • | | • | |
| 3.51 | 3.50 | 3 | | | 0 | 0 | 3.50 |
| 3.52 0 | | | | | 0 | 0 | |
| 3.53 3.54 0 0 0 3.53 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.59-3.98) 0 0 0 3.59 3. | | | | | - | | |
| 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 0 3.59 | | | | | | | |
| Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | | | | | - | 1 -1 | |
| 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32) To BE COMPLETED BY CONTRACTOR | | Subtotal (sum of lines 3 01-3 40 minus sum of lines | | | | | |
| Total Interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32) To BE COMPLETED BY CONTRACTOR | 3. 77 | | | | ٥ | | 3. 77 |
| (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02 5.03 Provider to Program 5.50 5.51 5.52 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETILEMENT TO PROVIDER 6.02 SETILEMENT TO PROVIDER 6.02 SETILEMENT TO PROVIDER 6.03 Total Medicare program liability (see instructions) Contractor (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00 | 4 00 | / | | | | E40 202 | 4 00 |
| Tine 32) To Be CoMLETED BY CONTRACTOR | 4.00 | | | | ٩ | 347, 302 | 4.00 |
| TO BE CÓMPLETED BY CONTRACTOR S. 00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider O | | | | | | | |
| List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | | | |
| desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0 | F 00 | | | I | | | F 00 |
| Write "NONE" or enter a zero. (1) Program to Provider | 5.00 | | | | | | 5.00 |
| Program to Provider | | | | | | | |
| 5. 01 5. 02 5. 03 Provider to Program 5. 50 5. 51 5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) 0 0 0 0 5. 01 0 0 0 5. 50 0 0 0 0 5. 50 0 0 0 0 0 0 0 5. 50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | | |
| 5. 02 | | Program to Provider | | ı | - | _ | |
| 5.03 Provider to Program 0 | | | | • | | | |
| Provider to Program | | | | | | | |
| S. 50 S. 5 | 5. 03 | | | | 0 | 0 | 5. 03 |
| 5.51 0 | | Provider to Program | | | | _ | |
| 5.52 0 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 5.59 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | | |
| 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00 | | | | | - | 1 -1 | |
| 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00 | | | | | - | | 5. 52 |
| 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00 | 5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines | | | 0 | 0 | 5. 99 |
| the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00 | | 5. 50-5. 98) | | | | | |
| 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00 | 6.00 | | | | | | 6.00 |
| 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 0 0 6.02 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00 | | | | | | | |
| 7.00 Total Medicare program liability (see instructions) 0 549,302 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00 | 6. 01 | SETTLEMENT TO PROVIDER | | | 0 | 0 | 6.01 |
| Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00 | 6.02 | SETTLEMENT TO PROGRAM | | | 0 | 0 | 6.02 |
| Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00 | 7.00 | Total Medicare program liability (see instructions) | | | 0 | 549, 302 | 7.00 |
| 0 1.00 2.00 | | | | | Contractor | | |
| 0 1.00 2.00 | | | | | Number | (Mo/Day/Yr) | |
| | | | (|) | | | |
| | 8. 00 | Name of Contractor | | | | | 8. 00 |

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HOSPICE/PALLIATIVE MEDICINE FELLOWS*

PALLIATIVE CARE PROGRAM*

OTHER PHYSICIAN SERVICES*

TELEHEALTH/TELEMONI TORI NG*

71.00 OTHER NONREIMBURSABLE (SPECIFY)*

NURSING FACILITY ROOM & BOARD*

RESIDENTIAL CARE*

ADVERTI SI NG*

THRIFT STORE*

63.00

64.00

65.00

66.00

67 00

68.00

69 00

70.00

100.00 TOTAL

^{*} Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.

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

| | | | | Hospi ce I | |
|--------|--|-------------|---------------|------------|---------|
| | | ADJUSTMENTS | TOTAL (col. 5 | | |
| | | | ± col. 6) | | |
| | T | 6. 00 | 7. 00 | | |
| | GENERAL SERVICE COST CENTERS | _ | _ | | |
| 1. 00 | CAP REL COSTS-BLDG & FIXT* | 0 | - | | 1.00 |
| 2. 00 | CAP REL COSTS-MVBLE EQUIP* | 0 | - | | 2.00 |
| 3. 00 | EMPLOYEE BENEFITS DEPARTMENT* | 0 | 0 | | 3.00 |
| 4. 00 | ADMINISTRATIVE & GENERAL* | -15, 693 | | | 4.00 |
| 5. 00 | PLANT OPERATION & MAINTENANCE* | 0 | 48, 818 | | 5.00 |
| 6. 00 | LAUNDRY & LINEN SERVICE* | 0 | 0 | | 6.00 |
| 7. 00 | HOUSEKEEPI NG* | 0 | 0 | | 7.00 |
| 8. 00 | DI ETARY* | 0 | 0 | | 8.00 |
| 9. 00 | NURSI NG ADMI NI STRATI ON* | 0 | 0 | | 9.00 |
| 10.00 | ROUTINE MEDICAL SUPPLIES* | 0 | 255 | | 10.00 |
| 11. 00 | MEDI CAL RECORDS* | 0 | 0 | | 11.00 |
| 12.00 | STAFF TRANSPORTATION* | 0 | 0 | | 12.00 |
| 13. 00 | VOLUNTEER SERVICE COORDINATION* | 0 | 0 | | 13.00 |
| 14.00 | PHARMACY* | 0 | 0 | | 14.00 |
| 15.00 | PHYSICIAN ADMINISTRATIVE SERVICES* | 0 | 0 | | 15.00 |
| 16.00 | OTHER GENERAL SERVICE* | 0 | 0 | | 16.00 |
| 17.00 | PATIENT/RESIDENTIAL CARE SERVICES | | | | 17. 00 |
| | DIRECT PATIENT CARE SERVICE COST CENTERS | | | | |
| 25.00 | I NPATI ENT CARE-CONTRACTED** | 0 | 0 | | 25. 00 |
| 26.00 | PHYSI CI AN SERVI CES** | 0 | 26, 625 | | 26. 00 |
| 27. 00 | NURSE PRACTITIONER** | 0 | 0 | | 27. 00 |
| 28. 00 | REGI STERED NURSE** | 0 | 335, 417 | | 28. 00 |
| 29. 00 | LPN/LVN** | 0 | 0 | | 29. 00 |
| 30.00 | PHYSI CAL THERAPY** | 0 | 0 | | 30.00 |
| 31.00 | OCCUPATIONAL THERAPY** | 0 | 0 | | 31.00 |
| 32.00 | SPEECH/LANGUAGE PATHOLOGY** | 0 | 0 | | 32.00 |
| 33.00 | MEDICAL SOCIAL SERVICES** | 0 | 38, 333 | | 33.00 |
| 34.00 | SPI RI TUAL COUNSELI NG** | 0 | 0 | | 34.00 |
| 35.00 | DI ETARY COUNSELI NG** | 0 | 0 | | 35.00 |
| 36.00 | COUNSELING - OTHER** | 0 | 0 | | 36.00 |
| 37.00 | HOSPICE AIDE & HOMEMAKER SERVICES** | 0 | 28, 317 | | 37.00 |
| 38.00 | DURABLE MEDICAL EQUIPMENT/OXYGEN** | 0 | 0 | | 38.00 |
| 39.00 | PATI ENT TRANSPORTATI ON** | 0 | 0 | | 39.00 |
| 40.00 | I MAGING SERVICES** | 0 | 0 | | 40.00 |
| 41.00 | LABS & DIAGNOSTICS** | 0 | 0 | | 41.00 |
| 42.00 | MEDI CAL SUPPLI ES-NON-ROUTI NE** | 0 | 0 | | 42.00 |
| 42.50 | DRUGS CHARGED TO PATIENTS** | 0 | 0 | | 42. 50 |
| 43.00 | OUTPATIENT SERVICES** | 0 | 0 | | 43.00 |
| 44.00 | PALLIATIVE RADIATION THERAPY** | 0 | 0 | | 44.00 |
| 45.00 | PALLIATIVE CHEMOTHERAPY** | 0 | 0 | | 45.00 |
| 46.00 | OTHER PATIENT CARE SERVICES (SPECIFY) ** | 0 | 0 | | 46.00 |
| | NONREI MBURSABLE COST CENTERS | | | | |
| 60.00 | BEREAVEMENT PROGRAM * | 0 | 0 | | 60.00 |
| 61.00 | VOLUNTEER PROGRAM * | 0 | 0 | | 61.00 |
| 62.00 | FUNDRAI SI NG* | 0 | 0 | | 62.00 |
| 63.00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS* | 0 | 0 | | 63.00 |
| 64.00 | PALLIATIVE CARE PROGRAM* | 0 | 0 | | 64.00 |
| 65.00 | OTHER PHYSICIAN SERVICES* | 0 | 0 | | 65.00 |
| 66.00 | RESI DENTI AL CARE* | 0 | 0 | | 66.00 |
| 67.00 | ADVERTI SI NG* | 0 | ol ol | | 67. 00 |
| 68.00 | TELEHEALTH/TELEMONI TORI NG* | 0 | ol ol | | 68. 00 |
| 69.00 | THRI FT STORE* | 0 | o o | | 69.00 |
| 70.00 | NURSING FACILITY ROOM & BOARD* | 0 | o | | 70.00 |
| 71.00 | OTHER NONREIMBURSABLE (SPECIFY)* | 0 | o | | 71.00 |
| 100.00 | TOTAL | -15, 693 | 722, 099 | | 100. 00 |
| | | | | | |

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

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559

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423, 559

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423, 559 100. 00

45.00

46.00

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

| | | ADJUSTMENTS | TOTAL (col. 5 | |
|--------|--|-----------------|---------------|--------|
| | | 715000111151110 | ± col. 6) | |
| | | 6. 00 | 7.00 | |
| | DIRECT PATIENT CARE SERVICE COST CENTERS | | | |
| 25.00 | I NPATI ENT CARE-CONTRACTED | | | 25. 00 |
| 26.00 | PHYSICIAN SERVICES | 0 | 26, 306 | 26.00 |
| 27.00 | NURSE PRACTITIONER | 0 | 0 | 27. 00 |
| 28.00 | REGI STERED NURSE | 0 | 331, 401 | 28. 00 |
| 29.00 | LPN/LVN | 0 | 0 | 29. 00 |
| 30.00 | PHYSI CAL THERAPY | 0 | 0 | 30.00 |
| 31.00 | OCCUPATIONAL THERAPY | 0 | 0 | 31.00 |
| 32.00 | SPEECH/LANGUAGE PATHOLOGY | 0 | 0 | 32.00 |
| 33.00 | MEDICAL SOCIAL SERVICES | 0 | 37, 874 | 33.00 |
| 34.00 | SPI RI TUAL COUNSELI NG | 0 | 0 | 34.00 |
| 35.00 | DI ETARY COUNSELI NG | 0 | 0 | 35.00 |
| 36.00 | COUNSELING - OTHER | 0 | 0 | 36.00 |
| 37.00 | HOSPICE AIDE & HOMEMAKER SERVICES | 0 | 27, 978 | 37.00 |
| 38. 00 | DURABLE MEDICAL EQUIPMENT/OXYGEN | 0 | 0 | 38. 00 |
| 39. 00 | PATI ENT TRANSPORTATION | 0 | 0 | 39.00 |
| 40.00 | I MAGING SERVICES | 0 | 0 | 40.00 |
| 41. 00 | LABS & DI AGNOSTI CS | 0 | 0 | 41.00 |
| 42.00 | MEDI CAL SUPPLI ES-NON-ROUTI NE | 0 | 0 | 42.00 |
| 42. 50 | DRUGS CHARGED TO PATIENTS | 0 | 0 | 42. 50 |
| 43.00 | OUTPATI ENT SERVI CES | 0 | 0 | 43.00 |
| 44.00 | PALLIATIVE RADIATION THERAPY | 0 | 0 | 44.00 |
| 45. 00 | PALLI ATI VE CHEMOTHERAPY | 0 | 0 | 45.00 |
| 46. 00 | OTHER PATIENT CARE SERVICES (SPECIFY) | 0 | 0 | 46. 00 |
| 100.00 | TOTAL * | 0 | 423, 559 | 100.00 |

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

45.00

100. 00 TOTAL

PALLIATIVE CHEMOTHERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

| Health Financial Systems HE | NRY COUNTY MEMO | RIAL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|---------------|-----------------|--------------------------------|--------------------------------|---------|
| ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC | E INPATIENT | Provi der CC | | Peri od: | Worksheet 0-3 | |
| RESPITE CARE | | Hospi ce CCN | | rom 01/01/2021 o 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
| | | | | Hospi ce I | | |
| | SALARI ES | OTHER | SUBTOTAL | RECLASSI FI - | SUBTOTAL | |
| | | | (col. 1 + | CATI ONS | | |
| | 1. 00 | 2.00 | col. 2) 3.00 | 4. 00 | 5. 00 | |
| DIRECT PATIENT CARE SERVICE COST CENTERS | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 25. 00 I NPATI ENT CARE-CONTRACTED | | O | (| 0 | 0 | 25.00 |
| 26. 00 PHYSI CI AN SERVI CES | 84 | 0 | 84 | 0 | 84 | |
| 27. 00 NURSE PRACTITIONER | o | o | (| o o | 0 | 27. 00 |
| 28. 00 REGISTERED NURSE | 1, 057 | o | 1, 05 | 0 | 1, 057 | 28. 00 |
| 29. 00 LPN/LVN | O | o | (| 0 | 0 | 29. 00 |
| 30. 00 PHYSI CAL THERAPY | o | 0 | (| 0 | 0 | 30.00 |
| 31.00 OCCUPATIONAL THERAPY | o | o | (| 0 | 0 | 31.00 |
| 32.00 SPEECH/LANGUAGE PATHOLOGY | 0 | 0 | (| 0 | 0 | 32.00 |
| 33.00 MEDICAL SOCIAL SERVICES | 121 | 0 | 121 | 0 | 121 | 33.00 |
| 34.00 SPIRITUAL COUNSELING | 0 | 0 | (| 0 | 0 | 34.00 |
| 35. 00 DI ETARY COUNSELI NG | 0 | 0 | (| 0 | 0 | 35.00 |
| 36.00 COUNSELING - OTHER | 0 | 0 | (| 0 | 0 | 36.00 |
| 37.00 HOSPICE AIDE & HOMEMAKER SERVICES | 89 | 0 | 89 | 0 | 89 | 37.00 |
| 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN | 0 | 0 | (| 0 | 0 | 38.00 |
| 39. 00 PATIENT TRANSPORTATION | 0 | 0 | (| 0 | 0 | 39.00 |
| 40.00 I MAGI NG SERVI CES | 0 | 0 | (| 0 | 0 | 40.00 |
| 41.00 LABS & DIAGNOSTICS | 0 | 0 | (| 0 | 0 | 41.00 |
| 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE | 0 | 0 | (| 0 | 0 | 42.00 |
| 42.50 DRUGS CHARGED TO PATIENTS | 0 | 0 | (| 0 | 0 | 42. 50 |
| 43. 00 OUTPATIENT SERVICES | 0 | 0 | (| 0 | 0 | 43.00 |
| 44.00 PALLIATIVE RADIATION THERAPY | 0 | 0 | (| 0 | 0 | 44.00 |
| 45. 00 PALLI ATI VE CHEMOTHERAPY | 0 | 0 | (| 0 | 0 | 45. 00 |
| 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) | 0 | 0 | (| 0 | 0 | 46.00 |
| 100.00 TOTAL * | 1, 351 | 0 | 1, 351 | 0 | 1, 351 | 100.00 |

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

| | | ADJUSTMENTS | TOTAL (col. 5 | | |
|--------|--|-------------|--------------------|---|--------|
| | | 6. 00 | ± col . 6) 7.00 | | |
| | DIRECT PATIENT CARE SERVICE COST CENTERS | 0.00 | 7.00 | | |
| 25. 00 | I NPATI ENT CARE-CONTRACTED | 0 | 0 | | 25. 00 |
| 26. 00 | PHYSI CI AN SERVI CES | 0 | 84 | | 26. 00 |
| 27. 00 | NURSE PRACTITIONER | | 0 | | 27. 00 |
| 28. 00 | REGI STERED NURSE | 0 | 1, 057 | | 28. 00 |
| 29. 00 | LPN/LVN | 0 | 0 | | 29. 00 |
| 30. 00 | PHYSI CAL THERAPY | 0 | o | | 30.00 |
| 31. 00 | OCCUPATIONAL THERAPY | 0 | o | | 31.00 |
| 32. 00 | SPEECH/LANGUAGE PATHOLOGY | 0 | o | | 32.00 |
| 33. 00 | MEDICAL SOCIAL SERVICES | 0 | 121 | | 33.00 |
| 34.00 | SPIRITUAL COUNSELING | 0 | o | | 34.00 |
| 35.00 | DI ETARY COUNSELING | 0 | o | | 35.00 |
| 36.00 | COUNSELING - OTHER | 0 | o | | 36.00 |
| 37.00 | HOSPICE AIDE & HOMEMAKER SERVICES | 0 | 89 | | 37.00 |
| 38.00 | DURABLE MEDICAL EQUIPMENT/OXYGEN | 0 | O | | 38.00 |
| 39.00 | PATIENT TRANSPORTATION | 0 | o | | 39.00 |
| 40.00 | I MAGING SERVICES | 0 | o | | 40.00 |
| 41.00 | LABS & DIAGNOSTICS | 0 | o | | 41.00 |
| 42.00 | MEDICAL SUPPLIES-NON-ROUTINE | 0 | o | | 42.00 |
| 42.50 | DRUGS CHARGED TO PATIENTS | 0 | o | | 42.50 |
| 43.00 | OUTPATIENT SERVICES | 0 | 0 | | 43.00 |
| 44.00 | PALLIATIVE RADIATION THERAPY | 0 | 0 | | 44.00 |
| 45.00 | PALLIATIVE CHEMOTHERAPY | 0 | 0 | | 45.00 |
| 46.00 | OTHER PATIENT CARE SERVICES (SPECIFY) | 0 | 0 | | 46.00 |
| 100.00 | TOTAL * | 0 | 1, 351 | 1 | 100.00 |

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

| Health Financial Systems HE | NRY COUNTY MEMOI | RIAL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|------------------|----------------|------------|----------------------------------|-----------------|------------------|
| ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC | CE GENERAL | Provi der CC | | Peri od: | Worksheet 0-4 | |
| I NPATI ENT CARE | | Hospice CCN | | From 01/01/2021 Fo 12/31/2021 | Date/Time Pre | narod: |
| | | Tiospi ce cciv | 1. 15-1504 | 10 12/31/2021 | 5/26/2022 3: 4 | |
| | | | | Hospi ce I | | |
| | SALARI ES | OTHER | SUBTOTAL | RECLASSI FI - | SUBTOTAL | |
| | | | (col. 1 + | CATI ONS | | |
| | | | col . 2) | | | |
| DUDGOT DATI SUT CARS OFFICE COOT OFFITEDO | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| DI RECT PATIENT CARE SERVICE COST CENTERS | | ما | | | 0 | 1 25 00 |
| 25. 00 I NPATI ENT CARE-CONTRACTED 26. 00 PHYSI CI AN SERVI CES | 235 | 0 | 23! | , | 0 235 | 25. 00 26. 00 |
| 27. 00 NURSE PRACTITIONER | 235 | 0 | 23 | 0 | 235 | 27.00 |
| 28. 00 REGISTERED NURSE | 2, 959 | 0 | 2, 95 | | 2, 959 | |
| 29. 00 LPN/LVN | 2, 737 | 0 | 2, 75 | | 2, 737 | 29.00 |
| 30. 00 PHYSICAL THERAPY | | 0 | , | | 0 | 30.00 |
| 31. 00 OCCUPATIONAL THERAPY | | 0 | · | | 0 | 31.00 |
| 32. 00 SPEECH/LANGUAGE PATHOLOGY | | 0 | · | | 0 | 32.00 |
| 33. 00 MEDICAL SOCIAL SERVICES | 338 | Ö | 338 | 0 | 338 | 33.00 |
| 34. 00 SPIRITUAL COUNSELING | 0 | 0 | (| 0 | 0 | 34.00 |
| 35. 00 DI ETARY COUNSELING | o | o | (| 0 | 0 | 35.00 |
| 36. 00 COUNSELING - OTHER | o | 0 | (| 0 | 0 | 36.00 |
| 37.00 HOSPICE AIDE & HOMEMAKER SERVICES | 250 | o | 250 | 0 | 250 | 37.00 |
| 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN | o | O | (| 0 | 0 | 38.00 |
| 39.00 PATIENT TRANSPORTATION | 0 | 0 | (| 0 | 0 | 39.00 |
| 40.00 I MAGING SERVICES | O | 0 | (| 0 | 0 | 40.00 |
| 41.00 LABS & DIAGNOSTICS | 0 | 0 | (| 0 | 0 | 41.00 |
| 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE | 0 | 0 | (| 0 | 0 | 42.00 |
| 42.50 DRUGS CHARGED TO PATIENTS | 0 | 0 | (| 0 | 0 | 42. 50 |
| 43.00 OUTPATIENT SERVICES | 0 | 0 | (| 0 | 0 | 43.00 |
| 44.00 PALLIATIVE RADIATION THERAPY | 0 | 0 | (| 0 | 0 | 44.00 |
| 45.00 PALLIATIVE CHEMOTHERAPY | 0 | 0 | (| 0 | 0 | 45. 00 |
| 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) | 0 | 0 | (| 0 | 0 | 46. 00 |
| 100.00 TOTAL * | 3, 782 | 0 | 3, 78 | 2 0 | 3, 782 | 100.00 |

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

| | | ADJUSTMENTS | TOTAL (col. 5 | |
|--------|--|-------------|---------------|--------|
| | | | ± col. 6) | |
| | | 6. 00 | 7. 00 | |
| | DIRECT PATIENT CARE SERVICE COST CENTERS | | | |
| 25.00 | I NPATI ENT CARE-CONTRACTED | 0 | 0 | 25.00 |
| 26.00 | PHYSI CI AN SERVI CES | 0 | 235 | 26.00 |
| 27.00 | NURSE PRACTITIONER | 0 | 0 | 27.00 |
| 28.00 | REGI STERED NURSE | 0 | 2, 959 | 28. 00 |
| 29. 00 | LPN/LVN | 0 | 0 | 29. 00 |
| 30.00 | PHYSI CAL THERAPY | 0 | 0 | 30.00 |
| 31.00 | OCCUPATI ONAL THERAPY | 0 | 0 | 31.00 |
| 32.00 | SPEECH/LANGUAGE PATHOLOGY | 0 | 0 | 32.00 |
| 33.00 | MEDICAL SOCIAL SERVICES | 0 | 338 | 33.00 |
| 34.00 | SPI RI TUAL COUNSELI NG | 0 | 0 | 34.00 |
| 35.00 | DI ETARY COUNSELI NG | 0 | 0 | 35.00 |
| 36.00 | COUNSELING - OTHER | 0 | 0 | 36.00 |
| 37. 00 | HOSPICE AIDE & HOMEMAKER SERVICES | 0 | 250 | 37.00 |
| 38. 00 | DURABLE MEDICAL EQUIPMENT/OXYGEN | 0 | 0 | 38.00 |
| 39. 00 | PATI ENT TRANSPORTATION | 0 | 0 | 39.00 |
| 40.00 | I MAGI NG SERVI CES | 0 | 0 | 40.00 |
| 41. 00 | LABS & DI AGNOSTI CS | 0 | 0 | 41.00 |
| 42.00 | MEDI CAL SUPPLI ES-NON-ROUTI NE | 0 | 0 | 42.00 |
| 42. 50 | DRUGS CHARGED TO PATIENTS | 0 | 0 | 42. 50 |
| 43.00 | OUTPATIENT SERVICES | 0 | 0 | 43.00 |
| 44.00 | PALLIATIVE RADIATION THERAPY | 0 | 0 | 44.00 |
| 45.00 | PALLIATIVE CHEMOTHERAPY | 0 | 0 | 45. 00 |
| 46. 00 | OTHER PATIENT CARE SERVICES (SPECIFY) | 0 | 0 | 46. 00 |
| 100.00 | TOTAL * | 0 | 3, 782 | 100.00 |

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

| | ILLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET SES FOR ALLOCATION | Provi der C | | Period: From 01/01/2021 To 12/31/2021 | Worksheet 0-5 Date/Time Pre 5/26/2022 3:4 | pared: |
|--------------------------------------|--|-------------|---|--|--|----------------------------------|
| | | | | Hospi ce I | | • |
| | Descriptions | | HOSPICE DIRECT EXPENSES (see instructions) | GENERAL SERVICE EXPENSES FROM WKST B PART I (see | TOTAL EXPENSES (sum of cols. 1 + 2) | |
| | | | | instructions) | | |
| | | | 1.00 | 2.00 | 3. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | |
| 1. 00 2. 00 3. 00 | CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT | | | 0 0 0 0 167, 512 | 0 0 167, 512 | 1.00 2.00 3.00 |
| 4. 00 5. 00 6. 00 | ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE | | | 8 63, 459 0 0 | 404, 657 112, 277 0 | 4. 00 5. 00 6. 00 |
| 7. 00 8. 00 9. 00 | HOUSEKEEPI NG DI ETARY NURSI NG ADMI NI STRATI ON | | | 0 13, 570 0 0 0 0 | 13, 570 0 0 | 7.00 8.00 9.00 |
| 10. 00 11. 00 12. 00 | ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION | | | 0 1, 267 | 2, 338 1, 267 0 | 11. 00 12. 00 |
| 13. 00 14. 00 15. 00 | VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES | | | 0 0 0 0 | 0 0 | 13.00 14.00 15.00 |
| 16. 00 17. 00 | OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES LEVEL OF CARE | | | 0 0 | 0 | 16.00 17.00 |
| 50. 00 51. 00 52. 00 53. 00 | HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE | | 423, 55 1, 35 3, 78 | 1 | 0 423, 559 1, 351 3, 782 | 50.00 51.00 52.00 53.00 |
| | NONREI MBURSABLE COST CENTERS | | 27.12 | =1 | 37.32 | |
| 60. 00 61. 00 | BEREAVEMENT PROGRAM VOLUNTEER PROGRAM | | | 0 | 0 | 60.00 61.00 |
| 62. 00 63. 00 64. 00 | FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM | | | 0 0 0 | 0 0 0 | 62.00 63.00 64.00 |
| 65. 00 66. 00 67. 00 | OTHER PHYSICIAN SERVICES RESIDENTIAL CARE ADVERTISING | | | 0 | 0 | 65. 00 66. 00 67. 00 |
| 68. 00 69. 00 70. 00 | TELEHEALTH/TELEMONI TORI NG THRI FT STORE NURSI NG FACI LI TY ROOM & BOARD | | | 0 0 0 | 0 | 68. 00 69. 00 70. 00 |
| 71.00 | OTHER NONREI MBURSABLE (SPECIFY) | | • | 0 | 0 | 71.00 |

0 99.00 1, 130, 313 100.00

722, 099

408, 214

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

| | | INICI COUNTI IVILIVIC | | | | a Of TOTH CMS-2 | 2332-10 |
|--------|---|-----------------------|------------------------------|--------------|---|---|------------|
| COST A | ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE | ERVICE COSTS | Provi der CO Hospi ce CCI | | Period: From 01/01/2021 To 12/31/2021 | Worksheet 0-6 Part I Date/Time Pre 5/26/2022 3:4 | pared: |
| | | | | | Hospi ce I | 0, 20, 2022 0 | <u>o p</u> |
| | Descriptions | TOTAL | CAP REL BLDG | CAP REL MVBL | | SUBTOTAL | |
| | beset i per ons | EXPENSES | & FLX | EQUI P | BENEFITS | SOBTOTAL | |
| | | LAFLINGLS | αιιλ | LUUIF | DEPARTMENT | | |
| | | 0 | 1. 00 | 2.00 | 3. 00 | 3A | |
| | GENERAL SERVICE COST CENTERS | 0 | 1.00 | 2.00 | 3.00 | 3A | |
| 1. 00 | CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2. 00 | CAP REL COSTS-BLDG & FIXI | 0 | U | | | | 2.00 |
| | | 4/7 540 | | | 0 4/7 540 | | 1 |
| 3. 00 | EMPLOYEE BENEFITS DEPARTMENT | 167, 512 | 0 | | 0 167, 512 | 404 457 | 3.00 |
| 4. 00 | ADMINISTRATIVE & GENERAL | 404, 657 | 0 | | 0 | 404, 657 | 4.00 |
| 5. 00 | PLANT OPERATION & MAINTENANCE | 112, 277 | 0 | | 0 0 | 112, 277 | 1 |
| 6. 00 | LAUNDRY & LINEN SERVICE | 0 | 0 | | 이 | 0 | 6. 00 |
| 7. 00 | HOUSEKEEPI NG | 13, 570 | 0 | | 0 | 13, 570 | |
| 8.00 | DI ETARY | 0 | 0 | | 0 0 | 0 | 8. 00 |
| 9.00 | NURSING ADMINISTRATION | 0 | 0 | | 0 0 | 0 | 9.00 |
| 10.00 | ROUTINE MEDICAL SUPPLIES | 2, 338 | 0 | | 0 0 | 2, 338 | 10.00 |
| 11.00 | MEDI CAL RECORDS | 1, 267 | 0 | | 0 0 | 1, 267 | 11.00 |
| 12.00 | STAFF TRANSPORTATION | 0 | 0 | | o o | 0 | 1 |
| 13. 00 | VOLUNTEER SERVICE COORDINATION | 0 | 0 | | 0 | 0 | 13.00 |
| 14. 00 | PHARMACY | 0 | 0 | | | 0 | 14.00 |
| 15. 00 | PHYSICIAN ADMINISTRATIVE SERVICES | ٥ | 0 | | | 0 | 15.00 |
| 16. 00 | OTHER GENERAL SERVICE | | 0 | | | 0 | 16.00 |
| 17. 00 | PATIENT/RESIDENTIAL CARE SERVICES | | 0 | | | 0 | 17.00 |
| 17.00 | LEVEL OF CARE | | 0 | | <u> </u> | 0 | 17.00 |
| 50.00 | HOSPICE CONTINUOUS HOME CARE | 0 | | | | 0 | 50.00 |
| 51. 00 | HOSPICE CONTINUOUS HOME CARE | 423, 559 | | | 165, 506 | 589, 065 | |
| | HOSPICE ROUTINE HOWE CARE HOSPICE INPATIENT RESPITE CARE | | 0 | | | · · | 1 |
| 52.00 | | 1, 351 | 0 | | 0 528 | 1, 879 | |
| 53. 00 | HOSPICE GENERAL INPATIENT CARE | 3, 782 | 0 | | 0 1, 478 | 5, 260 | 53.00 |
| | NONREI MBURSABLE COST CENTERS | | | ı | | | ,,,,,, |
| 60.00 | BEREAVEMENT PROGRAM | 0 | 0 | | 0 | 0 | 60.00 |
| 61.00 | VOLUNTEER PROGRAM | 0 | 0 | | 0 | 0 | 61.00 |
| 62. 00 | FUNDRAI SI NG | 0 | 0 | | 0 0 | 0 | 62.00 |
| 63.00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS | 0 | 0 | | 0 0 | 0 | 63.00 |
| 64.00 | PALLIATIVE CARE PROGRAM | 0 | 0 | | 0 | 0 | 64.00 |
| 65.00 | OTHER PHYSICIAN SERVICES | 0 | 0 | | 0 | 0 | 65.00 |
| 66.00 | RESI DENTI AL CARE | 0 | 0 | | 0 0 | 0 | 66.00 |
| 67.00 | ADVERTI SI NG | 0 | 0 | | 0 0 | 0 | 67.00 |
| 68.00 | TELEHEALTH/TELEMONI TORI NG | o | 0 | | o o | 0 | 68.00 |
| 69.00 | THRI FT STORE | ol | 0 | | ol ol | 0 | 69.00 |
| 70. 00 | NURSING FACILITY ROOM & BOARD | ام | _ | | | 0 | 70.00 |
| 71. 00 | OTHER NONREIMBURSABLE (SPECIFY) | ام | n | | ol ol | 0 | 71.00 |
| 99. 00 | NEGATI VE COST CENTER | ا | n | | | ŭ | 99.00 |
| | TOTAL | 1, 130, 313 | 0 | | 0 167, 512 | 1, 130, 313 | |
| | -1 | ., .55, 510 | Ü | 1 | -1 .5., 512 | ., .55, 616 | 1.30.00 |

| | ILLOCATION - HOSPITAL-BASED HOSPICE GENERAL S | ERVICE COSTS | | CN: 15-0030 | Peri od: From 01/01/2021 | Worksheet 0-6 | |
|--------|---|------------------|--------------|--------------|-----------------------------|-----------------------------|------------------|
| | | | Hospi ce CC | N: 15-1564 | To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | epared: 13 pm |
| | | | | | Hospi ce I | | |
| | Descriptions | ADMI NI STRATI V | PLANT | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | |
| | ' | E & GENERAL | OPERATION & | LINEN SERVIC | E | | |
| | | | MAI NTENANCE | | | | |
| | | 4. 00 | 5. 00 | 6.00 | 7. 00 | 8. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 3.00 | EMPLOYEE BENEFITS DEPARTMENT | | | | | | 3.00 |
| 4.00 | ADMINISTRATIVE & GENERAL | 404, 657 | | | | | 4.00 |
| 5.00 | PLANT OPERATION & MAINTENANCE | 62, 610 | 174, 887 | ' | | | 5.00 |
| 6.00 | LAUNDRY & LINEN SERVICE | 0 | 0 | | 0 | | 6.00 |
| 7.00 | HOUSEKEEPI NG | 7, 567 | 0 | | 21, 137 | | 7.00 |
| 8. 00 | DI ETARY | 0 | 0 | | 0 | 0 | 8.00 |
| 9. 00 | NURSI NG ADMI NI STRATI ON | 0 | 0 | | 0 | | 9.00 |
| 10.00 | ROUTINE MEDICAL SUPPLIES | 1, 304 | 0 | | 0 | | 10.00 |
| 11. 00 | MEDI CAL RECORDS | 707 | 0 | | 0 | | 11.00 |
| 12. 00 | STAFF TRANSPORTATION | 0 | 0 | | 0 | | 12.00 |
| 13. 00 | VOLUNTEER SERVICE COORDINATION | 0 | 0 | | 0 | | 13. 00 |
| 14. 00 | PHARMACY | 0 | 0 | | 0 | | 14.00 |
| | PHYSICIAN ADMINISTRATIVE SERVICES | 0 | 0 | | 0 | | 15.00 |
| 16. 00 | OTHER GENERAL SERVICE | 0 | 0 | | 0 | | 16.00 |
| 17. 00 | PATIENT/RESIDENTIAL CARE SERVICES | 0 | Ô | | 0 | | 17. 00 |
| 17.00 | LEVEL OF CARE | | | 1 | | | 17.00 |
| 50.00 | HOSPICE CONTINUOUS HOME CARE | 0 | | | | | 50.00 |
| 51. 00 | HOSPICE ROUTINE HOME CARE | 328, 488 | | | | | 51.00 |
| | HOSPICE INPATIENT RESPITE CARE | 1, 048 | 46, 051 | | 0 5, 566 | 0 | 1 |
| | HOSPICE GENERAL INPATIENT CARE | 2, 933 | 128, 836 | | 0 15, 571 | l ő | |
| 00.00 | NONREI MBURSABLE COST CENTERS | 2, 700 | 120,000 | 1 | 10,071 | | 30.00 |
| 60.00 | BEREAVEMENT PROGRAM | 0 | 0 | ol . | 0 | | 60.00 |
| 61. 00 | VOLUNTEER PROGRAM | 0 | 0 | | 0 | | 61.00 |
| | FUNDRAI SI NG | 0 | 0 | | 0 | | 62.00 |
| 63. 00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS | 0 | 0 | | 0 | | 63.00 |
| 64. 00 | PALLIATIVE CARE PROGRAM | 0 | 0 | | 0 | | 64.00 |
| | OTHER PHYSICIAN SERVICES | | 0 | | 0 | | 65.00 |
| 66. 00 | RESI DENTI AL CARE | | 0 | | 0 0 | 0 | |
| | ADVERTI SI NG | | 0 | | | 0 | 67.00 |
| 68. 00 | TELEHEALTH/TELEMONI TORI NG | | 0 | | 0 | | 68.00 |
| 69. 00 | THRIFT STORE | | | | | | 69.00 |
| | NURSING FACILITY ROOM & BOARD | | | Ί | | | 70.00 |
| | | | _ | J | | _ | |
| | OTHER NONREI MBURSABLE (SPECIFY) | | 0 | (| 0 0 | 0 | |
| | NEGATIVE COST CENTER | 404 (57 | 174 007 | | 0 21 127 | 0 | |
| 100.00 | TUTAL | 404, 657 | 174, 887 | I | 0 21, 137 | l 0 | 100. 00 |

| Hear th | Financiai Systems H | ENRY COUNTY MEMO | JRIAL HUSPITAL | - | in Lie | U OF FORM CMS-2 | 2552-10 |
|---------|---|------------------|----------------|------------|-----------------|-----------------|---------|
| COST A | ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S | ERVICE COSTS | Provi der C | | Peri od: | Worksheet 0-6 |) |
| | | | | | From 01/01/2021 | Part I | |
| | | | Hospi ce CC | N: 15-1564 | To 12/31/2021 | | |
| | | | | | Heeni ee I | 5/26/2022 3: 4 | -3 pm |
| | Descriptions | MUDCLNC | DOUTI NE | MEDICAL | Hospi ce I | VOLUNTEED | |
| | Descriptions | NURSI NG | ROUTI NE | MEDI CAL | STAFF | VOLUNTEER | |
| | | ADMI NI STRATI O | MEDI CAL | RECORDS | TRANSPORTATIO | SERVI CE | |
| | | N | SUPPLI ES | | N | COORDI NATI ON | |
| | I | 9. 00 | 10. 00 | 11. 00 | 12. 00 | 13. 00 | |
| | GENERAL SERVICE COST CENTERS | T | | T | T | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 3.00 | EMPLOYEE BENEFITS DEPARTMENT | | | | | | 3.00 |
| 4.00 | ADMINISTRATIVE & GENERAL | | | | | | 4.00 |
| 5.00 | PLANT OPERATION & MAINTENANCE | | | | | | 5.00 |
| 6.00 | LAUNDRY & LINEN SERVICE | | | | | | 6.00 |
| 7.00 | HOUSEKEEPI NG | | | | | | 7.00 |
| 8. 00 | DI ETARY | | | | | | 8.00 |
| 9. 00 | NURSI NG ADMI NI STRATI ON | | | | | | 9.00 |
| 10.00 | ROUTINE MEDICAL SUPPLIES | 0 | 3, 642 | | | | 10.00 |
| 11. 00 | MEDICAL RECORDS | | 3, 042 | 1, 97 | 4 | | 11.00 |
| | STAFF TRANSPORTATION | | | 1, 97 | 4 | | 12.00 |
| 12.00 | | 0 | | | 0 | | 1 |
| 13. 00 | VOLUNTEER SERVICE COORDINATION | 0 | | | 0 | 0 | |
| 14.00 | PHARMACY | 0 | | | 0 | 0 | 14.00 |
| 15. 00 | PHYSICIAN ADMINISTRATIVE SERVICES | 0 | | | 0 | 0 | 15. 00 |
| 16. 00 | OTHER GENERAL SERVICE | 0 | | | 0 | 0 | 16. 00 |
| 17.00 | PATIENT/RESIDENTIAL CARE SERVICES | | | | | | 17.00 |
| | LEVEL OF CARE | | | | | | |
| 50.00 | HOSPICE CONTINUOUS HOME CARE | 0 | 0 | | 0 0 | 0 | 50.00 |
| 51.00 | HOSPICE ROUTINE HOME CARE | 0 | 3, 599 | 1, 95 | 1 0 | 0 | 51.00 |
| 52.00 | HOSPICE INPATIENT RESPITE CARE | ol | 11 | | 6 0 | 0 | 52.00 |
| 53.00 | HOSPICE GENERAL INPATIENT CARE | 0 | 32 | 1 | 7 0 | 0 | 53.00 |
| | NONREI MBURSABLE COST CENTERS | -1 | | · | | | 1 |
| 60.00 | BEREAVEMENT PROGRAM | 0 | | | 0 | 0 | 60.00 |
| 61. 00 | VOLUNTEER PROGRAM | l o | | | 0 | · - | 61.00 |
| 62. 00 | FUNDRAI SI NG | | | | 0 | Ö | 62.00 |
| 63.00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS | | | | 0 | 0 | 63.00 |
| | | | | | 0 | 1 | 1 |
| 64.00 | PALLIATIVE CARE PROGRAM | 0 | | | 0 | 0 | 64.00 |
| 65.00 | OTHER PHYSICIAN SERVICES | 0 | | | 0 | 0 | 65.00 |
| 66. 00 | RESI DENTI AL CARE | 0 | | | 0 | 0 | 66.00 |
| 67. 00 | ADVERTI SI NG | 0 | | | 0 | 0 | 67.00 |
| 68. 00 | TELEHEALTH/TELEMONI TORI NG | 0 | | | 0 | 0 | 68. 00 |
| 69. 00 | THRI FT STORE | 0 | | | 0 | 0 | 69. 00 |
| 70.00 | NURSING FACILITY ROOM & BOARD | | | | | l | 70.00 |
| 71.00 | OTHER NONREIMBURSABLE (SPECIFY) | 0 | | | 0 | 0 | |
| 99. 00 | NEGATIVE COST CENTER | 0 | 0 | 1 | 0 0 | 0 | 99.00 |
| 100.00 | TOTAL | 0 | 3, 642 | 1, 97 | 4 0 | 0 | 100.00 |
| | • | • | | • | | | - |

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-0030 Peri od: Worksheet 0-6 From 01/01/2021 Part I Hospice CCN: 15-1564 12/31/2021 Date/Time Prepared: 5/26/2022 3:43 pm Hospi ce I PHARMACY PHYSI CI AN OTHER GENERAL PATI ENT/ TOTAL Descriptions ADMI NI STRATI V SERVI CE RESI DENTI AL E SERVICES CARE SERVICES 14.00 15.00 16.00 17.00 18.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 2 00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 ROUTINE MEDICAL SUPPLIES 10.00 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 14.00 PHARMACY 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 15.00 0 OTHER GENERAL SERVICE 16.00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 0 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 0 50.00 0 0 50.00 0 0 HOSPICE ROUTINE HOME CARE 923, 103 51.00 51.00 0 52.00 HOSPICE INPATIENT RESPITE CARE 0 0 54, 561 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 152, 649 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 0 0 0 0 0 0 0 0 0 0 60.00 0

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70.00

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VOLUNTEER PROGRAM

RESIDENTIAL CARE

PALLIATIVE CARE PROGRAM

OTHER PHYSICIAN SERVICES

TELEHEALTH/TELEMONI TORI NG

71.00 OTHER NONREIMBURSABLE (SPECIFY)

NURSING FACILITY ROOM & BOARD

HOSPICE/PALLIATIVE MEDICINE FELLOWS

FUNDRAI SI NG

ADVERTI SI NG

THRIFT STORE

99. 00 NEGATI VE COST CENTER

61.00

62.00

63.00

64.00

65.00

66.00

67 00

68.00

69.00

70.00

100.00 TOTAL

| Heal th | Financial Systems H | ENRY COUNTY MEN | MORIAL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|---|------------------------|------------------------------------|------------------------------------|---|--|---------|
| COST A | LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S TICAL BASIS | ERVICE COSTS | Provi der CC Hospi ce CCI | | Period: From 01/01/2021 To 12/31/2021 | Worksheet 0-6 Part II Date/Time Pre 5/26/2022 3:4 | pared: |
| | | | | | Hospi ce I | | |
| | Cost Center Descriptions | & FIX (SQUARE FEET) | CAP REL MVBLE EQUI P (DOLLAR | EMPLOYEE BENEFITS DEPARTMENT | RECONCI LI ATI O N | ADMI NI STRATI V E & GENERAL (ACCUMULATED | |
| | | | VALUE) | (GROSS SALARI ES) | | COSTS) | |
| | | 1. 00 | 2. 00 | 3.00 | 4A | 4. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | 0 |) | | | | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | | 0 | | | | 2.00 |
| 3.00 | EMPLOYEE BENEFITS DEPARTMENT | 0 | 0 | 167, 51 | | | 3.00 |
| 4. 00 | ADMINISTRATIVE & GENERAL | 0 | 0 | | 0 -404, 657 | 725, 656 | 4. 00 |
| 5.00 | PLANT OPERATION & MAINTENANCE | 0 | 0 | | 0 | 112, 277 | 5. 00 |
| 6.00 | LAUNDRY & LINEN SERVICE | 0 | 0 | | 0 | 0 | 6. 00 |
| 7. 00 | HOUSEKEEPI NG | 0 | 0 | | 0 | 13, 570 | 7. 00 |
| 8. 00 | DI ETARY | 0 | 0 | | 0 | 0 | 8. 00 |
| 9. 00 | NURSING ADMINISTRATION | 0 | 0 | | 0 | 0 | 9. 00 |
| 10.00 | ROUTINE MEDICAL SUPPLIES | 0 | 0 | | 0 | 2, 338 | 10.00 |
| 11. 00 | MEDI CAL RECORDS | 0 | 0 | | 0 | 1, 267 | 11. 00 |
| 12.00 | STAFF TRANSPORTATION | 0 | 0 | | 0 | 0 | 12.00 |
| 13.00 | VOLUNTEER SERVICE COORDINATION | 0 | 0 | | 0 | 0 | 13.00 |
| 14.00 | PHARMACY | 0 | 0 | | 0 | 0 | 14.00 |
| 15 00 | DUVCICIANI ADMINISTRATIVE SERVICES | | ıl 🕠 | | | Λ . | 15 00 |

| Health Financial Systems | HENRY COUNTY MEN | MORIAL HOSPITAL | In Lieu of Form CMS-2552-10 | | | |
|---|------------------|-----------------|-----------------------------|----------------------------|--------------------------------|--|
| COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S STATISTICAL BASIS | SERVICE COSTS | | | Period: From 01/01/2021 | Worksheet 0-6 Part II | |
| | | Hospi ce CC | N: 15-1564 | To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
| | | | | Hospi ce I | | |
| Cost Center Descriptions | PLANT | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | NURSI NG | |
| | OPERATION & | LINEN SERVICE | (SQUARE FEET) | (IN-FACILITY | ADMI NI STRATI O | |
| | MAI NTENANCE | (IN-FACILITY | | DAYS) | N | |
| | (SQUARE FEET) | DAYS) | | | (DI RECT NURS. | |
| | , | , | | | LDC) | |

| | | | | | Hospice i | , | |
|--------|---|------------------|---------------|---------------|--------------|------------------|--------|
| | Cost Center Descriptions | PLANT | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | NURSI NG | |
| | | OPERATION & | LINEN SERVICE | (SQUARE FEET) | (IN-FACILITY | ADMI NI STRATI O | |
| | | MAI NTENANCE | (IN-FACILITY | , , | DAYS) | l N | |
| | | (SQUARE FEET) | DAYS) | | • / | (DI RECT NURS. | |
| | | (040/1112 / 221) | 3,, | | | HRS.) | |
| | | 5. 00 | 6. 00 | 7.00 | 8. 00 | 9. 00 | |
| | GENERAL SERVICE COST CENTERS | 3.00 | 0.00 | 7.00 | 0.00 | 7. 00 | |
| 1. 00 | CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| 2. 00 | CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 3.00 | EMPLOYEE BENEFITS DEPARTMENT | | | | | | 3.00 |
| | | | | | | | 1 |
| 4.00 | ADMI NI STRATI VE & GENERAL | 0.000 | | | | | 4.00 |
| 5. 00 | PLANT OPERATION & MAINTENANCE | 2, 290 | 1 | | | | 5.00 |
| 6. 00 | LAUNDRY & LINEN SERVICE | | 0 | | | | 6. 00 |
| 7. 00 | HOUSEKEEPI NG | 0 |) | 2, 290 | | | 7. 00 |
| 8.00 | DI ETARY | C |) | 0 | 0 | | 8. 00 |
| 9.00 | NURSING ADMINISTRATION | C | | 0 | | 0 | 9. 00 |
| 10.00 | ROUTINE MEDICAL SUPPLIES | | | 0 | | 0 | 10.00 |
| 11. 00 | MEDI CAL RECORDS | 0 | | 0 | | 0 | 11.00 |
| 12. 00 | STAFF TRANSPORTATION | | | 0 | | 0 | 12.00 |
| 13. 00 | VOLUNTEER SERVICE COORDINATION | | | ١ | | 0 | 13.00 |
| 14. 00 | PHARMACY | | | | | 0 | 14.00 |
| | | | | | | _ | |
| 15.00 | PHYSI CI AN ADMINI STRATI VE SERVI CES | | / | 0 | | 0 | 15.00 |
| 16. 00 | OTHER GENERAL SERVICE | |) | 0 | | 0 | 16.00 |
| 17. 00 | PATI ENT/RESI DENTI AL CARE SERVI CES | C |) | 0 | | | 17. 00 |
| | LEVEL OF CARE | | | | | | |
| 50.00 | HOSPICE CONTINUOUS HOME CARE | | | | | 0 | 50.00 |
| 51.00 | HOSPICE ROUTINE HOME CARE | | | | | 0 | 51.00 |
| 52.00 | HOSPICE INPATIENT RESPITE CARE | 603 | 0 | 603 | 0 | 0 | 52.00 |
| 53.00 | HOSPICE GENERAL INPATIENT CARE | 1, 687 | 0 | 1, 687 | 0 | 0 | 53.00 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| 60.00 | BEREAVEMENT PROGRAM | C |) | 0 | | 0 | 60.00 |
| 61.00 | VOLUNTEER PROGRAM | 0 | | 0 | | 0 | 61.00 |
| 62. 00 | FUNDRAI SI NG | | | 0 | | 0 | 62.00 |
| 63. 00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS | | | ١ | | 0 | 63.00 |
| 64. 00 | PALLIATIVE CARE PROGRAM | | | | | 0 | 64.00 |
| 65. 00 | OTHER PHYSICIAN SERVICES | | | | | 0 | 65.00 |
| | 1 | | íl . | | 0 | _ | |
| 66.00 | RESI DENTI AL CARE | | 0 | | 0 | _ | 66.00 |
| 67. 00 | ADVERTI SI NG | | <u> </u> | 0 | | 0 | 67.00 |
| 68. 00 | TELEHEALTH/TELEMONI TORI NG | |) | 0 | | 0 | 68. 00 |
| 69. 00 | THRI FT STORE | 0 |) | 0 | | 0 | 69. 00 |
| 70. 00 | NURSING FACILITY ROOM & BOARD | | | | | | 70.00 |
| 71.00 | OTHER NONREIMBURSABLE (SPECIFY) | C |) 0 | 0 | 0 | 0 | 71.00 |
| 99.00 | NEGATI VE COST CENTER | | | | | | 99.00 |
| 100.00 | COST TO BE ALLOCATED (per Wkst. 0-6, Part I | 174, 887 | · 0 | 21, 137 | 0 | 0 | 100.00 |
| | UNIT COST MULTIPLIER | 76. 369869 | l . | | 0. 000000 | | |
| | | | | | | 1 | |

| | | HENRY COUNTY MEMO | | | In Lie | u of Form CMS- | <u>2552-10</u> |
|---|---|---|-------------------------------|---------------------------------|--|--|----------------|
| | ILLOCATION - HOSPITAL-BASED HOSPICE GENERAL STICAL BASIS | SERVICE COSTS | Provi der Co | | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet 0-6 Part II Date/Time Pre 5/26/2022 3:4 | epared: |
| | | | | | Hospi ce I | | |
| | Cost Center Descriptions | ROUTINE | MEDI CAL | STAFF | VOLUNTEER | PHARMACY | |
| | | MEDI CAL SUPPLI ES (PATI ENT DAYS) | RECORDS (PATI ENT DAYS) | TRANSPORTATI N (MI LEAGE) | O SERVI CE COORDI NATI ON (HOURS OF SERVI CE) | (CHARGES) | |
| | | 10, 00 | 11. 00 | 12.00 | 13.00 | 14. 00 | |
| | GENERAL SERVICE COST CENTERS | .0.00 | | .2.00 | .0.00 | | |
| 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 | CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES | 3, 174 | 3, 174 | | 0 0 0 0 0 0 0 0 | 0 0 0 | 15. 00 |
| | LEVEL OF CARE | | | | | | |
| 50. 00 51. 00 52. 00 53. 00 | HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE | 0 3, 136 10 28 | 0 3, 136 10 28 | | 0 0 0 0 0 0 0 0 | 0 0 0 0 | 51.00 52.00 |
| 60. 00 | NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM | | | | 0 0 | 0 | 60.00 |
| 61. 00 | VOLUNTEER PROGRAM | | | | | 0 | |
| 62.00 | FUNDRAI SI NG | | | | 0 0 | 0 | |
| 63.00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS | | | | 0 0 | 0 | 63.00 |
| 64. 00 | PALLIATIVE CARE PROGRAM | | | | 0 0 | 0 | |
| 65.00 | OTHER PHYSICIAN SERVICES | | | | 0 | 0 | |
| 66.00 | RESI DENTI AL CARE | | | | 0 0 | 0 | |
| 67. 00 | ADVERTI SI NG | | | I | 0 0 | 0 | 67.00 |

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1, 974 0. 621928

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0 100. 00 0. 000000 101. 00

68. 00 | TELEHEALTH/TELEMONI TORI NG

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

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

| Health Financial Systems | HENRY COUNTY MEMORIAL HOSPITAL | - | In Lie | u of Form CMS-2552-10 |
|---|--|---------------------------|-----------------|---|
| COST ALLOCATION - HOSPITAL-BASED HOSPICE GENER STATISTICAL BASIS | AL SERVICE COSTS Provider C Hospice CC | CN: 15-0030 N: 15-1564 | From 01/01/2021 | Worksheet 0-6 Part II Date/Time Prepared: |

| Cost Center Descriptions | | | | | | | 5/26/2022 3: 4 | 13 pm |
|--|--------|---------------------------------------|------------------|---------------|---------------|------------|----------------|---------|
| ADMINISTRATIVE SERVICE F. SERVICE F. SERVICES PASIS S. P. DATA CAPE SERVICES PASIS S. P. DATA S. P. P. DATA S. P. P. DATA S. | , | | | | | Hospi ce I | | |
| CAPPAIR CAPP | | Cost Center Descriptions | PHYSI CI AN | OTHER GENERAL | PATI ENT/ | | | |
| CPATIENT DAYS) | | | ADMI NI STRATI V | SERVI CE | RESI DENTI AL | | | |
| DAYS DAYS DAYS | | | E SERVICES | (SPECI FY | CARE SERVICES | | | |
| 15.00 16.00 17.00 | | | (PATI ENT | BASIS) | (IN-FACILITY | | | |
| 15.00 16.00 17.00 | | | DAYS) | <u> </u> | DAYS) | | | |
| 1. 00 | | | 15. 00 | 16.00 | 17.00 | | | |
| 1. 00 | | GENERAL SERVICE COST CENTERS | _ | 1 | • | | | |
| 2. 00 | 1. 00 | | | | | | | 1.00 |
| 3. 00 ADMIN ISTRATI VE & GENERAL 4.00 5.00 ADMIN ISTRATI VE & GENERAL 4.00 6.00 LAUNDRY & LINEN SERVICE 5.00 6.00 LAUNDRY & LINEN SERVICE 6.00 6 | | | | | | | | 1 |
| 4. 00 ADMINI STRATIVE & GENERAL | | | | | | | | 1 |
| 5.00 | | | | | | | | |
| 6. 00 LAUNDRY & LI NEN SERVI CE | | | | | | | | |
| 7. 00 HOUSEKEEPING | | | | | | | | |
| 8. 00 NURSI NG ADMINISTRATION 9. 00 | | | | | | | | 1 |
| 9. 00 NURSI NG ADMI NI STRATI ON 10. 00 ROUTI NE MEDI CAL SUPPLI ES 110. 00 ROUTI NE MEDI CAL SUPPLI ES 110. 00 REDI CAL RECORDS 110. 00 MEDI CAL RECORDS 111. 00 MEDI CAL RECORDS 111. 00 TAL. 10. 00 STAFF TRANSPORTATI ON 112. 00 COULINTEER SERVI CE COORDI NATI ON 112. 00 COULINTEER SERVI CE COORDI NATI ON 113. 00 COULINTEER SERVI CE COORDI NATI ON 114. 00 PHARMACY 114. 00 PHYSI CI AN ADMI NI STRATI VE SERVI CES 0 TAL. 00 COULINTEER SERVI CES 0 TAL. 00 COULINTEER SERVI CE TAL. 00 COULINTEER SERVI CE TAL. 00 COULINTEER SERVI CE TAL. 00 COULINTEER SERVI CE TAL. 00 COULINTEER SERVI CE TAL. 00 COULINTEER SERVI CE TAL. 00 COULINTEER SERVI CES 0 COULINTEER S | | | | | | | | 1 |
| 10. 00 ROUTINE MEDICAL SUPPLIES 10. 00 11. 00 MEDICAL RECORDS 11. 00 12. 00 STAFF TRANSPORTATION 12. 00 13. 00 VOLUNTEER SERVICE COORDINATION 13. 00 14. 00 PHARMACY 14. 00 15. 00 PHYSI CI AN ADMINISTRATIVE SERVICES 0 15. 00 16. 00 OTHER GENERAL SERVICE 0 17. 00 17. 00 DATIENT/RESIDENTIAL CARE SERVICES 0 17. 00 18. 00 OTHER GENERAL SERVICES 0 17. 00 19. 00 HOSPI CE ROUTINUOUS HOME CARE 0 0 51. 00 19. 00 HOSPI CE CONTINUOUS HOME CARE 0 0 51. 00 19. 00 HOSPI CE ROUTINE HOME CARE 0 0 0 52. 00 19. 00 HOSPI CE ROUTINE HOME CARE 0 0 0 52. 00 19. 00 HOSPI CE GENERAL INPATIENT CARE 0 0 0 52. 00 19. 00 HOSPI CE GENERAL INPATIENT CARE 0 0 0 53. 00 10. 00 BEREAVEMENT PROGRAM 0 60. 00 10. 00 BEREAVEMENT PROGRAM 0 61. 00 10. 00 VOLUNTEER PROGRAM 0 62. 00 10. 00 FUNDRAI SI NG 0 63. 00 10. 00 CHUNDRAI SI NG 0 64. 00 10. 00 OTHER PHYSI CI AN SERVICES 0 0 65. 00 10. 00 OTHER PHYSI CI AN SERVICES 0 0 66. 00 10. 00 OTHER PHYSI CI AN SERVICES 0 0 66. 00 10. 00 OTHER PHYSI CI AN SERVICES 0 0 66. 00 10. 00 OTHER PHYSI CI AN SERVICES 0 0 66. 00 10. 00 OTHER PHYSI CI AN SERVICES 0 0 66. 00 10. 00 OTHER PHYSI CI AN SERVICES 0 0 66. 00 10. 00 OTHER PHYSI CI AN SERVICES 0 0 0 66. 00 10. 00 OTHER PHYSI CI AN SERVICES 0 0 0 10. 00 OTHER PHYSI CI AN SERVICES 0 0 0 0 10. 00 OTHER PHYSI CI AN SERVICES 0 0 0 0 10. 00 OTHER PROGRAM 0 0 0 0 10. 00 OTHER PHYSI CI AN SERVICES 0 0 0 0 10. 00 OTHER PHYSI CI AN SERVICES 0 0 0 0 10. 00 OTHER PHYSI CI AN SERVICES 0 0 0 0 10. 00 OTHER PHYSI CI AN SERVICES 0 0 0 0 0 10. 00 OTHER PHYSI CI AN SERVICES 0 0 0 0 0 10. 00 OTHER PHYSI CI AN SERVICES 0 0 0 0 0 10. 00 | | | • | | | | | 1 |
| 11. 00 MEDICAL RECORDS 11. 00 12. 00 STAFF TRANSPORTATION 12. 00 13. 00 VOLUNTEER SERVICE COORDINATION 13. 00 VOLUNTEER SERVICE COORDINATION 14. 00 PHARMACY 15. 00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15. 00 16. 00 OTHER GENERAL SERVICE 0 0 16. 00 OTHER GENERAL SERVICES 0 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 0 0 0 0 0 0 | | | | | | | | 1 |
| 12. 00 13. 00 VOLUNTEER SERVI CE COORDINATION 13. 00 14. 00 PHARIMACY 14. 00 15. 00 PHARIMACY 15. 00 PHARIMACY 15. 00 PHYSI CI AN ADMINI STRATI VE SERVI CES 0 15. 00 16. 00 0 0 0 17. 00 | | | | | | | | |
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| 14. 00 15. 00 17. 00 18. 00 19 | | | | | | | | 1 |
| 15. 00 PHYSICI AN ADMINISTRATIVE SERVICES 0 16. 00 116. 00 117. 00 PATE GENERAL SERVICE 0 16. 00 116. 00 117. 00 PATE GENERAL SERVICES 0 0 116. 00 117. 00 PATE GENERAL SERVICES 0 0 116. 00 117. 00 PATE GENERAL SERVICES 0 0 17. 00 PATE GENERAL SERVICES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | | | • |
| 16. 00 OTHER GENERAL SERVICE 0 0 16. 00 17. 00 17. 00 PATI ENT/RESI DENTI AL CARE SERVICES 0 0 17. 00 17. | | | | | | | | |
| 17. 00 | | | | 1 | | | | 1 |
| LEVEL OF CARE 50.00 HOSPI CE CONTI NUOUS HOME CARE 0 0 0 0 51.00 | | | | | 1 | | | |
| 50.00 HOSPI CE CONTI NUOUS HOME CARE 0 0 0 0 51.00 51.00 HOSPI CE ROUTI NE HOME CARE 0 0 0 0 51.00 52.00 HOSPI CE INPATI ENT RESPI TE CARE 0 0 0 0 0 52.00 53.00 HOSPI CE GENERAL INPATI ENT CARE 0 0 0 0 53.00 NONREI MBURSABLE COST CENTERS | 17. 00 | PATI ENT/RESI DENTI AL CARE SERVI CES | | | (| | | 17. 00 |
| 51.00 | | | | | | | | |
| 52.00 HOSPICE INPATIENT RESPITE CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | |) (|) | | | 50.00 |
| HOSPICE GENERAL INPATIENT CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 51.00 | HOSPICE ROUTINE HOME CARE | |) (| | | | 51.00 |
| NONREI MBURSABLE COST CENTERS 0 60.00 | 52.00 | HOSPICE INPATIENT RESPITE CARE | |) (|) (| | | 52.00 |
| 60. 00 BEREAVEMENT PROGRAM 0 60. 00 61. 00 VOLUNTEER PROGRAM 0 61. 00 62. 00 FUNDRAI SI NG 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 0 66. 00 67. 00 ADVERTI SI NG 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 68. 00 69. 00 THIR FT STORE 0 69. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD 70. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 71. 00 NEGATI VE COST CENTER 99. 00 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 0 0 0 60. 00 0 0 0 61. 00 62. 00 62. 00 62. 00 62. 00 62. 00 63. 00 64. 00 64. 00 64. 00 65. 00 0 0 65. 00 0 0 66. 00 0 0 67. 00 0 0 67. 00 0 0 68. 00 0 0 69. 00 0 0 69. 00 0 0 60. 00 0 60. 00 0 0 60. 00 0 0 60. 00 0 0 60. 00 0 60. 00 0 0 60. 00 0 0 60. 00 0 0 60. 00 0 60. 00 0 0 60. 00 0 0 60. 00 0 0 60. 00 0 60. 00 0 0 60. 00 0 0 60. 00 0 0 60. 00 0 60. 00 0 0 60. 00 0 0 60. 00 0 0 60. 00 0 60. 00 0 0 60. 00 0 60. 00 0 0 60. 00 0 60. 00 0 60. 00 0 0 60. 00 | 53.00 | HOSPICE GENERAL INPATIENT CARE | | | | | | 53.00 |
| 61. 00 VOLUNTEER PROGRAM 0 61. 00 62. 00 63. 00 63. 00 63. 00 64. 00 64. 00 65. 00 | | NONREI MBURSABLE COST CENTERS | • | | | | | 1 |
| 62. 00 | 60.00 | BEREAVEMENT PROGRAM | | (| | | | 60.00 |
| 63. 00 | 61.00 | VOLUNTEER PROGRAM | | | ol | | | 61.00 |
| 63. 00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 64. 00 PALLIATIVE CARE PROGRAM 65. 00 OTHER PHYSICIAN SERVICES 66. 00 RESIDENTIAL CARE 66. 00 ADVERTISING 67. 00 ADVERTISING 68. 00 TELEHEALTH/TELEMONITORING 69. 00 THRIFT STORE 70. 00 NURSING FACILITY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECIFY) 99. 00 NEGATIVE COST CENTER 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 0 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 | 62.00 | FUNDRAI SI NG | | | ol | | | 62.00 |
| 64.00 PALLIATIVE CARE PROGRAM 65.00 OTHER PHYSICIAN SERVICES 66.00 RESIDENTIAL CARE 0 0 0 0 0 66.00 67.00 ADVERTISING 68.00 TELEHEALTH/TELEMONITORING 69.00 THRIFT STORE 70.00 NURSING FACILITY ROOM & BOARD 71.00 OTHER NONREI MBURSABLE (SPECIFY) 99.00 NEGATIVE COST CENTER 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 0 64.00 65.00 66.00 67.00 68.00 67.00 68.00 69.00 71.00 71.00 71.00 | 63.00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS | | | | | | |
| 65. 00 OTHER PHYSICIAN SERVICES 66. 00 RESIDENTIAL CARE 0 0 0 0 0 66. 00 67. 00 ADVERTISING 68. 00 TELEHEALTH/TELEMONITORING 69. 00 THRIFT STORE 70. 00 NURSING FACILITY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECIFY) 99. 00 NEGATIVE COST CENTER 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | | | |
| 66. 00 RESI DENTI AL CARE 0 0 0 0 67. 00 67. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 69. 00 7HIR FT STORE 0 70. 00 NURSI NG FACILITY ROOM & BOARD 70. 00 OTHER NONREI MBURSABLE (SPECIFY) 0 0 71. 00 99. 00 NEGATI VE COST CENTER 99. 00 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 0 0 0 0 0 100. 00 | | | | | | | | 1 |
| 67. 00 ADVERTISING 0 67. 00 68. 00 TELEHEALTH/TELEMONITORING 0 68. 00 69. 00 THRIFT STORE 0 69. 00 70. 00 NURSING FACILITY ROOM & BOARD 70. 00 71. 00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 99. 00 NEGATIVE COST CENTER 99. 00 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 0 0 0 67. 00 68. 00 68. 00 69. 00 68. 00 69. 00 69. 00 0 0 70. 00 0 0 70. 00 0 0 70. 00 0 70. | | | | | | | | 1 |
| 68. 00 TELEHEALTH/TELEMONI TORI NG 0 68. 00 69. 00 THRI FT STORE 0 69. 00 70. 00 NURSI NG FACILITY ROOM & BOARD 70. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 71. 00 NEGATI VE COST CENTER 99. 00 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 100. 00 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. | | | | 1 | | | | |
| 69.00 THRIFT STORE 0 69.00 70.00 NURSING FACILITY ROOM & BOARD 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 71.00 99.00 NEGATIVE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 0 0 0 0 | | | | | | | | |
| 70.00 NURSING FACILITY ROOM & BOARD 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 0 0 0 0 0 0 | | | | | á | | | 1 |
| 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 71.00 99.00 NEGATIVE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 0 0 0 0 100.00 | | | | | Ί | | | |
| 99.00 NEGATIVE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 0 0 0 100.00 | | | | | | | | |
| 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 0 0 0 100.00 | | · · · · · · · · · · · · · · · · · · · | | 'l | 'l | 7 | | |
| | | | | | , | | | 1 |
| 101. 00 UNIT COST MOLTIPLIER 0. 000000 0. 000000 0. 000000 101. 00 | | | | 0 00000 | 0 00000 | ול | | |
| | 101.00 | UNII COSI WULIIPLIEK | 0.000000 | J 0. 00000C | J 0. 00000C | 기 | | 1101.00 |

| Health Financial Systems | HENRY | COUNTY | MEMORI | AL HOSPIT | AL | | In Lieu | u of Form CMS-2552-10 |
|--|-------------|--------|--------|------------|------|---------|----------------------------------|-----------------------|
| APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHAF | RED SERVICE | COSTS | BY | Provi der | CCN: | 15-0030 | Peri od: | Worksheet 0-7 |
| LEVEL OF CARE | | | | Hospi ce (| CCN: | 15-1564 | From 01/01/2021 To 12/31/2021 | Date/Time Prepared: |
| | | | | · | | | 11 | 5/26/2022 3: 43 pm |

| Cost Center Descriptions From Wkst. C, Part I, Col. Pline 0 1.00 2.00 3.00 4.00 |
|--|
| Cost Center Descriptions From Wkst. C, Cost to HCHC HRHC HIRC Part I, Col. Charge Ratio 9 line |
| Part I, Col. Charge Ratio |
| 0 1.00 2.00 3.00 4.00 |
| |
| ANCILLARY SERVICE COST CENTERS |
| 1. 00 PHYSI CAL THERAPY 66. 00 0. 648610 0 0 0 1. 00 2. 00 OCCUPATI ONAL THERAPY 67. 00 0. 472713 0 0 0 0 2. 00 |
| 3.00 SPEECH PATHOLOGY 68.00 0.482605 0 0 3.00 |
| 4. 00 DRUGS CHARGED TO PATIENTS 73. 00 0. 416073 0 0 4. 00 |
| 5. 00 DURABLE MEDI CAL EQUI P-RENTED 96. 00 5. 00 6. 0 |
| 6. 00 LABORATORY 60. 00 0. 175730 0 0 0 6. 00 6. 01 BLOOD LABORATORY 60. 01 0. 000000 0 0 0 6. 01 |
| 7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.126832 0 0 0 7.00 |
| 8. 00 OTHER OUTPATIENT SERVICE COST CENTER 93. 00 8.00 |
| 9. 00 RADI OLOGY-THERAPEUTI C 55. 00 9. 00 |
| 10. 00 CARDI AC REHAB 76. 00 0. 281281 0 0 0 10. 00 |
| 11.00 Totals (sum of lines 1-11) |
| Charges by LOC LOC (from Provi der Records) |
| Cost Center Descriptions HGIP HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGIP (col. 1 |
| x col . 2) x col . 3) x col . 4) x col . 5) |
| 5. 00 6. 00 7. 00 8. 00 9. 00 |
| ANCILLARY SERVICE COST CENTERS 1. 00 PHYSICAL THERAPY 0 0 0 0 0 1.00 |
| 2. 00 OCCUPATI ONAL THERAPY 0 0 0 0 0 2. 00 |
| 3. 00 SPEECH PATHOLOGY 0 0 0 0 3. 00 |
| 4.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 4.00 |
| 5. 00 DURABLE MEDICAL EQUIP-RENTED 5. 00 |
| 6.00 LABORATORY 0 0 0 0 6.00 |
| 6. 01 BLOOD LABORATORY 0 0 0 6. 01 |
| 7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 7. 00 |
| 8. 00 OTHER OUTPATIENT SERVICE COST CENTER 8. 00 9. 00 RADIOLOGY-THERAPEUTIC 9. 00 |
| 9. 00 RADI OLOGY - THERAPEUTI C 10. 00 CARDI AC REHAB 0 0 0 0 10. 00 |
| 11. 00 Total's (sum of lines 1-11) 0 0 0 0 11.00 |

| Health Financial Systems | HENRY COUNTY MEMORI | AL HOSPITAL | In Lieu | of Form CMS-2552-10 |
|--|---------------------|-----------------------|-----------------------------|---------------------|
| CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM | COST | Provider CCN: 15-0030 | Peri od: From 01/01/2021 | Worksheet 0-8 |

Hospice CCN: 15-1564 From 01/01/2021 Date/Time Prepared: 5/26/2022 3:43 pm

| | | | | | 5/26/2022 3: 4: | 3 pm |
|--------|--|------------|-------------|------------|-----------------|--------|
| | | | | Hospi ce I | | |
| | | | TITLE XVIII | TITLE XIX | TOTAL | |
| | | | MEDI CARE | MEDI CAI D | | |
| | | | 1.00 | 2. 00 | 3. 00 | |
| | HOSPI CE CONTINUOUS HOME CARE | | | | | |
| 1.00 | Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0- | 7, col. 6, | | | 0 | 1.00 |
| | line 11) | | | | | |
| 2.00 | Total unduplicated days (Wkst. S-9, col. 4, line 10) | | | | 0 | 2.00 |
| 3.00 | Total average cost per diem (line 1 divided by line 2) | | | | 0.00 | 3.00 |
| 4.00 | Unduplicated program days (Wkst. S-9 col. as appropriate, line | e 10) | | 0 0 | | 4.00 |
| 5. 00 | Program cost (line 3 times line 4) | , | | 0 | | 5.00 |
| | HOSPI CE ROUTI NE HOME CARE | | | | | |
| 6. 00 | Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0- | 7. col. 7. | | | 923, 103 | 6.00 |
| | line 11) | .,, | | | 1=0, 100 | |
| 7.00 | Total unduplicated days (Wkst. S-9, col. 4, line 11) | | | | 3, 136 | 7.00 |
| 8.00 | Total average cost per diem (line 6 divided by line 7) | | | | 294. 36 | 8.00 |
| 9. 00 | Unduplicated program days (Wkst. S-9, col. as appropriate, li | ne 11) | 2, 54 | 3 125 | | 9.00 |
| 10.00 | Program cost (line 8 times line 9) | , | 748, 55 | | | 10.00 |
| | HOSPICE INPATIENT RESPITE CARE | | | | | |
| 11.00 | Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0- | 7, col. 8, | | | 54, 561 | 11.00 |
| | line 11) | | | | | |
| 12.00 | Total unduplicated days (Wkst. S-9, col. 4, line 12) | | | | 10 | 12.00 |
| 13.00 | Total average cost per diem (line 11 divided by line 12) | | | | 5, 456. 10 | 13.00 |
| 14.00 | Unduplicated program days (Wkst. S-9, col. as appropriate, li | ne 12) | | 5 0 | · | 14.00 |
| 15.00 | Program cost (line 13 times line 14) | ŕ | 27, 28 | 1 0 | | 15.00 |
| | HOSPI CE GENERAL I NPATI ENT CARE | | | <u>'</u> | | |
| 16.00 | Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0- | 7, col. 9, | | | 152, 649 | 16.00 |
| | line 11) | | | | | |
| 17.00 | Total unduplicated days (Wkst. S-9, col. 4, line 13) | | | | 28 | 17. 00 |
| 18.00 | Total average cost per diem (line 16 divided by line 17) | | | | 5, 451. 75 | 18.00 |
| 19.00 | Unduplicated program days (Wkst. S-9, col. as appropriate, li | ne 13) | 1 | 4 3 | | 19.00 |
| 20.00 | Program cost (line 18 times line 19) | ŕ | 76, 32 | 5 16, 355 | | 20.00 |
| | TOTAL HOSPICE CARE | | | , | | |
| 21.00 | | | | | 1, 130, 313 | 21.00 |
| 22. 00 | | | | | 3, 174 | |
| | Average cost per diem (line 21 divided by line 22) | | | | 356. 12 | |
| | 1 25 222 F2. 2. 2 (2 di Vidod 2) 11110 22) | | 1 | 1 | 1 0001.121 | |

| llool +h | Financial Cystems | NAL HOODETAL | la li o | u of Form CMC (| DEE2 10 | |
|----------|--|-----------------------------|--|---|---------|--|
| | Financial Systems HENRY COUNTY MEMORATION OF CAPITAL PAYMENT | Provider CCN: 15-0030 | Peri od: From 01/01/2021 To 12/31/2021 | w of Form CMS-2 Worksheet L Parts I-III Date/Time Pre 5/26/2022 3:4 | pared: | |
| | | Title XVIII | Hospi tal | PPS | | |
| | | | | | | |
| | | | | 1. 00 | | |
| | PART I - FULLY PROSPECTIVE METHOD | | | | | |
| | CAPITAL FEDERAL AMOUNT | | | | | |
| 1. 00 | Capital DRG other than outlier | | | 571, 417 | 1.00 | |
| 1. 01 | Model 4 BPCI Capital DRG other than outlier | | | 0 | 1.01 | |
| 2. 00 | Capital DRG outlier payments | | | 3, 265 | 2.00 | |
| 2. 01 | Model 4 BPCI Capital DRG outlier payments | | | 0 | 2. 01 | |
| 3. 00 | Total inpatient days divided by number of days in the cost r | eporting period (see ins | tructions) | 25. 48 | 3.00 | |
| 4.00 | Number of interns & residents (see instructions) | | | 0.00 | 4.00 | |
| 5.00 | Indirect medical education percentage (see instructions) | | | 0.00 | 5.00 | |
| 6. 00 | Indirect medical education adjustment (multiply line 5 by th | e sum of lines I and 1.0 | i, columns i and | 0 | 6. 00 | |
| 7. 00 | 1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions) | patient days (Worksheet | E, part A line | 0. 00 | 7. 00 | |
| 8. 00 | Percentage of Medicaid patient days to total days (see instr | uctions) | | 0.00 | 8.00 | |
| 9. 00 | Sum of lines 7 and 8 | | | 0. 00 | 9.00 | |
| 10.00 | Allowable disproportionate share percentage (see instruction | s) | | 0.00 | 10.00 | |
| 11. 00 | 3. (| | | | | |
| 12.00 | | | | | | |
| | | | | 574, 682 | 12.00 | |
| | | | | 1. 00 | | |
| | PART II - PAYMENT UNDER REASONABLE COST | | | | | |
| 1.00 | Program inpatient routine capital cost (see instructions) | | | 0 | 1.00 | |
| 2.00 | Program inpatient ancillary capital cost (see instructions) | | | 0 | 2.00 | |
| 3. 00 | Total inpatient program capital cost (line 1 plus line 2) | | | 0 | 3. 00 | |
| 4. 00 | Capital cost payment factor (see instructions) | | | 0 | 4.00 | |
| 5. 00 | Total inpatient program capital cost (line 3 x line 4) | | | 0 | 5. 00 | |
| | | | | 4 00 | | |
| | PART III - COMPUTATION OF EXCEPTION PAYMENTS | | | 1. 00 | | |
| 1. 00 | Program inpatient capital costs (see instructions) | | | 0 | 1.00 | |
| 2. 00 | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan | ces (see instructions) | | 0 | 2.00 | |
| 3.00 | Net program inpatient capital costs (line 1 minus line 2) | ces (see Thisti deti ons) | | 0 | 3.00 | |
| 4. 00 | Applicable exception percentage (see instructions) | | | 0.00 | 4.00 | |
| 5. 00 | Capital cost for comparison to payments (line 3 x line 4) | | | 0.00 | 5.00 | |
| 6. 00 | Percentage adjustment for extraordinary circumstances (see i | nstructions) | | 0.00 | 6.00 | |
| 7. 00 | Adjustment to capital minimum payment level for extraordinar | | x line 6) | 0.00 | 7.00 | |
| 8. 00 | Capital minimum payment level (line 5 plus line 7) | y 0.1.0a010.000 (1.1.10 2 . | | 0 | 8.00 | |
| 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 | | less line 9) | 0 | 10.00 | |
| 11. 00 | Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) | 1 1 3 1 | , | 0 | 11. 00 | |
| 12.00 | Net comparison of capital minimum payment level to capital p | ayments (line 10 plus li | ne 11) | 0 | 12.00 | |
| 13.00 | Current year exception payment (if line 12 is positive, ente | | | 0 | 13.00 | |
| 14.00 | Carryover of accumulated capital minimum payment level over | capital payment for the | following period | 0 | 14.00 | |
| | (if line 12 is negative, enter the amount on this line) | · · | | | | |
| 15.00 | Current year allowable operating and capital payment (see in | structions) | | 0 | 15. 00 | |
| 16. 00 | Current year operating and capital costs (see instructions) | | | 0 | 16.00 | |
| 17.00 | Current year exception offset amount (see instructions) | | | 0 | 17. 00 | |

| | Financial Systems HE SIS OF HOSPITAL-BASED RHC/FQHC COSTS | NRY COUNTY MEM | Provi der C | | Peri od: | u of Form CMS-2 Worksheet M-1 | |
|----------------|--|------------------|-------------|---------------|------------------|----------------------------------|--------|
| 711071213 | or a final time broke time, the desire | | | | From 01/01/2021 | | |
| | | | Component | CCN: 15-8520 | To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
| | | | | | RHC I | Cost | o piii |
| | | Compensati on | Other Costs | Total (col. 1 | Recl assi fi cat | Recl assi fi ed | |
| | | | | + col. 2) | i ons | Trial Balance | |
| | | | | | | (col. 3 + | |
| | | 4.00 | 0.00 | 2.00 | 4.00 | col . 4) | |
| | FACILITY HEALTH CARE CTAFE COCTO | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 1 00 | FACILITY HEALTH CARE STAFF COSTS | 1 005 245 | 20, 200 | 2 005 47 | 4 0 | 2 005 474 | 1 00 |
| 1. 00 2. 00 | Physi ci an Physi ci an Assi stant | 1, 985, 365 | 20, 309 | | 0 0 | 2, 005, 674 0 | 1 |
| 3. 00 | Nurse Practitioner | 687, 611 | 0 | | ٥ | _ | |
| 4. 00 | Visiting Nurse | 007,011 | 0 | 687, 61 | -214,030 | 473, 555 0 | |
| 5. 00 | Other Nurse | 458, 015 | 300 | 458, 31 | 5 0 | 458, 315 | |
| 6. 00 | Clinical Psychologist | 450, 015 0 | 300 | 450, 51 | | 438, 313 | 1 |
| 7. 00 | Clinical Social Worker | 60, 989 | 0 | 60, 98 | 0 | 60, 989 | |
| 8. 00 | Laboratory Techni ci an | 00, 707 | 0 | | | 00, 707 | |
| 9. 00 | Other Facility Health Care Staff Costs | 468, 004 | 0 | 468, 00 | ا ا | 468, 004 | |
| 10. 00 | Subtotal (sum of lines 1 through 9) | 3, 659, 984 | 20, 609 | | | | |
| 11. 00 | Physician Services Under Agreement | 3, 037, 704 N | 20,007 | 3,000,37 | 0 214,030 | 0, 400, 337 | 1 |
| 12. 00 | Physician Supervision Under Agreement | 0 | 0 | | 0 | 0 | |
| 13. 00 | Other Costs Under Agreement | 0 | 0 | | 0 | 0 | |
| 14. 00 | Subtotal (sum of lines 11 through 13) | 0 | 0 | | 0 | 0 | |
| 15. 00 | Medical Supplies | 0 | 134, 689 | 134, 68 | 9 0 | 134, 689 | |
| 16. 00 | Transportation (Health Care Staff) | 0 | 0 | | 0 | 0 | |
| 17.00 | Depreciation-Medical Equipment | 0 | 0 | | 0 | 0 | 17.00 |
| 18.00 | Professional Liability Insurance | 0 | 20, 014 | 20, 01 | 4 0 | 20, 014 | 18.00 |
| 19.00 | Other Health Care Costs | 0 | 0 | | 0 | 0 | 19.00 |
| 20.00 | Allowable GME Costs | | | | | | 20.00 |
| 21.00 | Subtotal (sum of lines 15 through 20) | 0 | 154, 703 | 154, 70 | 3 0 | 154, 703 | 21.00 |
| 22.00 | Total Cost of Health Care Services (sum of | 3, 659, 984 | 175, 312 | 3, 835, 29 | 6 -214, 056 | 3, 621, 240 | 22.00 |
| | lines 10, 14, and 21) | | | | | |] |
| | COSTS OTHER THAN RHC/FQHC SERVICES | | | | | | 1 |
| 23. 00 | | 0 | 0 | | 0 | 0 | |
| 24. 00 | Dental | 0 | 0 | 1 | 0 | 0 | |
| 25. 00 | Optometry | 0 | 0 | | 0 | 0 | |
| 25. 01 | Tel eheal th | 0 | 0 | | 0 | 0 | |
| 25. 02 | 9 | 0 | 0 | | 0 | 0 | |
| 26. 00 | All other nonreimbursable costs | 0 | 0 | ' | 0 | 0 | 20.00 |
| 27. 00 | Nonallowable GME costs | | | | | | 27.00 |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 through 27) | 0 | 0 | · | 0 | 0 | 28. 00 |
| | FACILITY OVERHEAD | | | | | | 1 |
| 29 ∩∩ | Facility Costs | 0 | 636, 927 | 636, 92 | 7 0 | 636, 927 | 29. 00 |
| | Administrative Costs | 1 093 824 | | | | | |

636, 927 1, 547, 246

2, 184, 173

2, 359, 485

1, 093, 824

1, 093, 824

4, 753, 808

636, 927 2, 641, 070

3, 277, 997

7, 113, 293

636, 927 1, 665, 629 2, 302, 556

5, 923, 796

-975, 441

-975, 441

-1, 189, 497

30.00

31.00

32.00

30.00 Administrative Costs

31.00

32.00

Total Facility Overhead (sum of lines 29 and

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

| Health Financial Systems | HENRY COUNTY MEMORIAL HOSPITAL | In Lieu | u of Form CMS-2552-10 |
|---|--------------------------------|-----------------------------|-----------------------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provi der CCN: 15-0030 | Peri od: From 01/01/2021 | Worksheet M-1 |
| | Component CCN: 15-8520 | To 12/31/2021 | Date/Time Prepared: |

| | | | Component | CCN: 15-8520 | То | 12/31/2021 | Date/Time Pro 5/26/2022 3:4 | |
|--------|--|-------------|--------------|--------------|----|------------|--------------------------------|--------|
| | | | | | | RHC I | Cost | |
| | | Adjustments | Net Expenses | | | | | |
| | | , | for | | | | | |
| | | | Allocation | | | | | |
| | | | (col. 5 + | | | | | |
| | | | col. 6) | | | | | |
| | | 6. 00 | 7. 00 | 1 | | | | |
| | FACILITY HEALTH CARE STAFF COSTS | | | ' | | | | |
| 1.00 | Physi ci an | 0 | 2, 005, 674 | | | | | 1.00 |
| 2.00 | Physician Assistant | ol | 0 | 1 | | | | 2.00 |
| 3. 00 | Nurse Practitioner | 0 | 473, 555 | | | | | 3.00 |
| 4. 00 | Visiting Nurse | o | 0 | , | | | | 4.00 |
| 5. 00 | Other Nurse | o | 458, 315 | | | | | 5.00 |
| 6. 00 | Clinical Psychologist | 0 | .00, 0.0 | | | | | 6.00 |
| 7. 00 | Clinical Social Worker | 0 | 60, 989 | | | | | 7.00 |
| 8. 00 | Laboratory Techni ci an | 0 | 00, 707 | | | | | 8.00 |
| 9. 00 | Other Facility Health Care Staff Costs | 0 | 468, 004 | 1 | | | | 9.00 |
| 10. 00 | Subtotal (sum of lines 1 through 9) | 0 | 3, 466, 537 | | | | | 10.00 |
| 11. 00 | Physician Services Under Agreement | 0 | 0, 400, 557 | 1 | | | | 11.00 |
| 12. 00 | Physician Supervision Under Agreement | 0 | 0 | 1 | | | | 12.00 |
| | | 0 | 0 | | | | | 13.00 |
| | Other Costs Under Agreement | U | 0 | | | | | |
| 14.00 | Subtotal (sum of lines 11 through 13) | 0 | 0 | | | | | 14.00 |
| 15.00 | Medical Supplies | 0 | 134, 689 | | | | | 15.00 |
| 16. 00 | Transportation (Health Care Staff) | 0 | 0 | 1 | | | | 16. 00 |
| 17. 00 | Depreciation-Medical Equipment | 0 | 0 | 1 | | | | 17. 00 |
| 18. 00 | Professional Liability Insurance | 0 | 20, 014 | 1 | | | | 18. 00 |
| | Other Health Care Costs | 0 | 0 | | | | | 19. 00 |
| 20.00 | Allowable GME Costs | | | | | | | 20.00 |
| 21. 00 | Subtotal (sum of lines 15 through 20) | 0 | 154, 703 | | | | | 21. 00 |
| 22.00 | Total Cost of Health Care Services (sum of | 0 | 3, 621, 240 |) | | | | 22. 00 |
| | lines 10, 14, and 21) | | | | | | | |
| | COSTS OTHER THAN RHC/FQHC SERVICES | | | | | | | |
| 23.00 | Pharmacy | 0 | 0 | 1 | | | | 23. 00 |
| 24.00 | Dental | 0 | 0 |) | | | | 24.00 |
| 25.00 | Optometry | 0 | 0 | | | | | 25.00 |
| 25. 01 | Tel eheal th | 0 | 0 | | | | | 25. 01 |
| 25.02 | Chronic Care Management | 0 | 0 | | | | | 25. 02 |
| 26.00 | All other nonreimbursable costs | 0 | 0 | | | | | 26.00 |
| 27.00 | Nonallowable GME costs | | | | | | | 27. 00 |
| 28.00 | Total Nonreimbursable Costs (sum of lines 23 | 0 | 0 |) | | | | 28. 00 |
| | through 27) | | | | | | | |
| | FACILITY OVERHEAD | | | | | | | |
| 29.00 | Facility Costs | -282, 694 | 354, 233 | | | | | 29. 00 |
| 30.00 | Administrative Costs | -157, 453 | 1, 508, 176 | | | | | 30.00 |
| 31.00 | Total Facility Overhead (sum of lines 29 and | -440, 147 | 1, 862, 409 | 1 | | | | 31.00 |
| | 30) | | | | | | | |
| 32.00 | Total facility costs (sum of lines 22, 28 | -440, 147 | 5, 483, 649 | 1 | | | | 32.00 |
| | and 31) | | | | | | | |
| | , | | | • | | | | • |

| | | NRY COUNTY MEM | | | | u of Form CMS-2 | |
|------------------|--|----------------|--------------|------------|----------------------------|-----------------------------|------------------|
| ANALY | SIS OF HOSPITAL-BASED RHC/FQHC COSTS | | Provi der C | | Period: From 01/01/2021 | Worksheet M-1 | |
| | | | Component | | To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | pared: 3 pm |
| | | | | | RHC II | Cost | |
| | | Compensation | Other Costs | | Recl assi fi cat | Recl assi fi ed | |
| | | | | + col . 2) | i ons | Trial Balance | |
| | | | | | | (col. 3 + | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | col . 4) 5. 00 | |
| | FACILITY HEALTH CARE STAFF COSTS | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 1. 00 | Physician | 3, 833, 657 | 94, 003 | 3, 927, 66 | 0 0 | 3, 927, 660 | 1.00 |
| 2. 00 | Physician Assistant | 3, 633, 637 | 74, 003 0 | 3, 727, 00 | | 3, 427, 000 | 1 |
| 3. 00 | Nurse Practitioner | 1, 942, 132 | 0 | 1, 942, 13 | 2 228, 987 | 2, 171, 119 | |
| 4. 00 | Visiting Nurse | 1, 742, 132 | 0 | 1, 742, 13 | n 220, 707 | 2, 17 1, 117 | 1 |
| 5. 00 | Other Nurse | 377, 086 | 0 | 377, 08 | 6 0 | 377, 086 | |
| 6. 00 | Clinical Psychologist | 0 | Ö | 31.1,33 | 0 0 | 0 | 6.00 |
| 7. 00 | Clinical Social Worker | 0 | 0 | | 27, 068 | 27, 068 | 7.00 |
| 8.00 | Laboratory Techni ci an | 0 | 0 | | 0 | 0 | 8.00 |
| 9.00 | Other Facility Health Care Staff Costs | 1, 218, 599 | 320 | 1, 218, 91 | 9 0 | 1, 218, 919 | 9.00 |
| 10.00 | Subtotal (sum of lines 1 through 9) | 7, 371, 474 | 94, 323 | 7, 465, 79 | 7 256, 055 | 7, 721, 852 | 10.00 |
| 11.00 | Physician Services Under Agreement | 0 | 0 | | 0 | 0 | 11.00 |
| 12.00 | | 0 | 0 | | 0 | 0 | 12.00 |
| 13.00 | Other Costs Under Agreement | 0 | 0 | | 0 | 0 | 13.00 |
| 14. 00 | | 0 | 0 | | 0 | 0 | |
| 15. 00 | Medical Supplies | 0 | 427, 411 | 427, 41 | 1 0 | 427, 411 | 1 |
| 16. 00 | Transportation (Health Care Staff) | 0 | 0 | | 0 | 0 | |
| 17. 00 | | 0 | 0 | | 0 | 0 | |
| 18.00 | | 0 | 0 | | 0 | 0 | 18.00 |
| 19. 00 20. 00 | | 0 | 0 | | 0 | 0 | 19. 00 20. 00 |
| 20.00 | Subtotal (sum of lines 15 through 20) | _ | 427, 411 | 427, 41 | 1 | 427, 411 | 21.00 |
| 22.00 | | 7, 371, 474 | | 7, 893, 20 | | | 1 |
| 22.00 | lines 10, 14, and 21) | 7,371,474 | 321, 734 | 7,073,20 | 230, 033 | 0, 149, 203 | 22.00 |
| | COSTS OTHER THAN RHC/FQHC SERVICES | | | | | | 1 |
| 23. 00 | | 0 | 0 | | 0 0 | 0 | 23. 00 |
| 24. 00 | Dental | 0 | Ö | | 0 0 | 0 | 24. 00 |
| 25. 00 | Optometry | 0 | 0 | | 0 | 0 | 25.00 |
| 25. 01 | Tel eheal th | 0 | 0 | | 0 0 | 0 | 25. 01 |
| 25. 02 | Chronic Care Management | 0 | 0 | | 0 0 | 0 | 25. 02 |
| 26.00 | All other nonreimbursable costs | 0 | 0 | | 0 0 | 0 | 26.00 |
| 27.00 | Nonallowable GME costs | | | | | | 27. 00 |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0 | 0 | | 0 | 0 | 28. 00 |
| | through 27) | | | | | | |

889, 715

889, 715

8, 261, 189

1, 453, 446

2, 436, 468 3, 889, 914

4, 411, 648

1, 453, 446

3, 326, 183

4, 779, 629

12, 672, 837

-1, 522, 326

-1, 522, 326

-1, 266, 271

1, 453, 446 1, 803, 857

3, 257, 303

11, 406, 566

29.00

30.00

31.00

32.00

FACILITY OVERHEAD
29.00 Facility Costs

31.00

30.00 Administrative Costs

Total Facility Overhead (sum of lines 29 and

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

| Health Financial Systems | HENRY COUNTY MEMORIAL HOSPITAL | In Lie | u of Form CMS-2552-10 |
|---|--------------------------------|-----------------------------|-----------------------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provi der CCN: 15-0030 | Peri od: From 01/01/2021 | Worksheet M-1 |
| | Component CCN: 15-8525 | To 12/31/2021 | Date/Time Prepared: |

| | | | Component | LCN: 15-8525 | 10 | 12/31/2021 | 5/26/2022 3:4 | |
|--------|--|------------------|--------------|--------------|----|------------|---------------|---------|
| | | | | | | RHC II | Cost | о рііі |
| | | Adjustments | Net Expenses | | | 1010 | 0031 | |
| | | riaj astiliorres | for | | | | | |
| | | | Allocation | | | | | |
| | | | (col. 5 + | | | | | |
| | | | col. 6) | | | | | |
| | | 6. 00 | 7. 00 | | | | | |
| | FACILITY HEALTH CARE STAFF COSTS | | | 1 | | | | |
| 1. 00 | Physi ci an | -1, 348, 024 | 2, 579, 636 | | | | | 1.00 |
| 2. 00 | Physician Assistant | 0 | 0 | i | | | | 2.00 |
| 3. 00 | Nurse Practitioner | 0 | 2, 171, 119 | | | | | 3.00 |
| 4.00 | Visiting Nurse | 0 | | i | | | | 4.00 |
| 5. 00 | Other Nurse | 0 | 377, 086 | | | | | 5.00 |
| 6. 00 | Clinical Psychologist | 0 | 0 | | | | | 6.00 |
| 7. 00 | Clinical Social Worker | 0 | 27, 068 | | | | | 7. 00 |
| 8. 00 | Laboratory Techni ci an | 0 | 0 | | | | | 8.00 |
| 9. 00 | Other Facility Health Care Staff Costs | 0 | 1, 218, 919 | | | | | 9.00 |
| 10.00 | Subtotal (sum of lines 1 through 9) | -1, 348, 024 | 6, 373, 828 | | | | | 10.00 |
| 11. 00 | Physician Services Under Agreement | 1,010,021 | 0, 0, 0, 020 | | | | | 11.00 |
| 12. 00 | Physician Supervision Under Agreement | 0 | 0 | | | | | 12.00 |
| 13. 00 | Other Costs Under Agreement | 0 | 0 | | | | | 13.00 |
| 14. 00 | Subtotal (sum of lines 11 through 13) | 0 | 0 | | | | | 14.00 |
| 15. 00 | Medical Supplies | 0 | 427, 411 | | | | | 15.00 |
| 16. 00 | Transportation (Health Care Staff) | 0 | 0 | 1 | | | | 16.00 |
| 17. 00 | Depreciation-Medical Equipment | 0 | 0 | | | | | 17. 00 |
| 18. 00 | Professional Liability Insurance | 0 | 0 | | | | | 18.00 |
| 19. 00 | Other Health Care Costs | 0 | 0 | | | | | 19.00 |
| 20. 00 | Allowable GME Costs | U | O | | | | | 20.00 |
| 21. 00 | Subtotal (sum of lines 15 through 20) | 0 | 427, 411 | | | | | 21.00 |
| 22. 00 | Total Cost of Health Care Services (sum of | -1, 348, 024 | 6, 801, 239 | • | | | | 22. 00 |
| 22.00 | lines 10, 14, and 21) | -1, 340, 024 | 0,001,237 | | | | | 22.00 |
| | COSTS OTHER THAN RHC/FQHC SERVICES | | | | | | | |
| 23. 00 | Pharmacy | 0 | 0 | | | | | 23. 00 |
| 24. 00 | Dental | 0 | 0 | | | | | 24. 00 |
| 25. 00 | Optometry | 0 | 0 | | | | | 25. 00 |
| 25. 01 | Tel eheal th | 0 | 0 | | | | | 25. 01 |
| 25. 02 | Chronic Care Management | 0 | 0 | | | | | 25. 02 |
| 26. 00 | All other nonreimbursable costs | 0 | 0 | | | | | 26.00 |
| 27. 00 | Nonal Lowable GME costs | J | 0 | | | | | 27. 00 |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0 | 0 | | | | | 28. 00 |
| 20.00 | through 27) | Ö | 0 | | | | | 20.00 |
| | FACILITY OVERHEAD | | | | | | | |
| 29. 00 | Facility Costs | -671, 315 | 782, 131 | | | | | 29.00 |
| 30. 00 | Admi ni strati ve Costs | -189, 078 | | | | | | 30.00 |
| 31. 00 | Total Facility Overhead (sum of lines 29 and | | | • | | | | 31.00 |
| 51.00 | 30) | 000, 373 | 2, 370, 710 | | | | |] 31.00 |
| 32.00 | Total facility costs (sum of lines 22, 28 | -2, 208, 417 | 9, 198, 149 | | | | | 32.00 |
| 32.00 | and 31) | 2,200,117 | ,,.,,,,,,,,, | | | | | 52.00 |
| | mile = :/ | ' | ı | 1 | | | | 1 |

| | | NRY COUNTY MEM | | | | u of Form CMS-2 | |
|--------|--|----------------|-------------|---------------|----------------------------|-----------------------------|----------|
| ANALYS | SIS OF HOSPITAL-BASED RHC/FQHC COSTS | | Provi der C | | Period: From 01/01/2021 | Worksheet M-1 | |
| | | | Component | | To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
| | | | | | RHC III | Cost | <u> </u> |
| | | Compensation | Other Costs | Total (col. 1 | Recl assi fi cat | Recl assi fi ed | |
| | | | | + col . 2) | i ons | Trial Balance | |
| | | | | | | (col. 3 + | |
| | | | | | | col. 4) | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | FACILITY HEALTH CARE STAFF COSTS | | | | | | |
| 1. 00 | Physi ci an | 265, 635 | 5, 588 | | | , | 1.00 |
| 2.00 | Physician Assistant | 0 | 0 | | 0 | 0 | 2.00 |
| 3.00 | Nurse Practitioner | 260, 685 | 0 | 260, 68 | | | 3. 00 |
| 4. 00 | Visiting Nurse | 0 | 0 | 1 | 0 | 0 | |
| 5.00 | Other Nurse | 71, 085 | 358 | 71, 44 | 3 0 | 71, 443 | 1 |
| 6. 00 | Clinical Psychologist | 0 | 0 | 1 | 0 | 0 | |
| 7. 00 | Clinical Social Worker | 0 | 0 | 1 | 0 | 0 | 7. 00 |
| 8.00 | Laboratory Techni ci an | 0 | 0 | 1 | 0 | 0 | |
| 9. 00 | Other Facility Health Care Staff Costs | 104, 846 | | 104, 84 | | 104, 846 | |
| 10.00 | Subtotal (sum of lines 1 through 9) | 702, 251 | 5, 946 | 708, 19 | | 708, 197 | 10.00 |
| 11. 00 | Physician Services Under Agreement | 0 | 0 | 1 | 0 | - | |
| 12. 00 | Physician Supervision Under Agreement | 0 | 0 | 1 | 0 | 1 | 12. 00 |
| 13. 00 | Other Costs Under Agreement | 0 | 0 | 1 | 0 | 0 | 13. 00 |
| 14.00 | Subtotal (sum of lines 11 through 13) | 0 | 0 | 1 | 0 | _ | |
| 15. 00 | Medical Supplies | 0 | 32, 123 | 32, 12 | | 02, .20 | 1 |
| 16.00 | Transportation (Health Care Staff) | 0 | 0 | 1 | 0 | 0 | |
| 17.00 | Depreciation-Medical Equipment | 0 | 0 | 1 | 0 | 0 | |
| 18.00 | Professional Liability Insurance | 0 | 0 | 1 | 0 | 0 | 18. 00 |
| 19. 00 | Other Health Care Costs | 0 | 0 | 1 | 0 | 0 | 1 . , |
| 20.00 | Allowable GME Costs | | | | | | 20.00 |
| 21. 00 | Subtotal (sum of lines 15 through 20) | 0 | 32, 123 | | | , | |
| 22. 00 | Total Cost of Health Care Services (sum of | 702, 251 | 38, 069 | 740, 32 | 0 | 740, 320 | 22. 00 |
| | lines 10, 14, and 21) | | | | | | |
| | COSTS OTHER THAN RHC/FQHC SERVICES | _ | _ | T | | 1 | |
| 23.00 | Pharmacy | 0 | 0 | | 0 | _ | 23.00 |
| 24.00 | Dental | 0 | 0 | 1 | 0 | 1 | 24.00 |
| 25.00 | Optometry | 0 | 0 | | 0 | 1 | 25.00 |
| 25. 01 | Tel eheal th | 0 | 0 | | 0 | 0 | 25. 01 |
| 25. 02 | Chronic Care Management | 0 | 0 | 1 | 0 | 0 | 25. 02 |
| 26.00 | All other nonreimbursable costs | 0 | 0 | 1 | 0 | 0 | 26.00 |
| 27. 00 | Nonallowable GME costs | _ | _ | | | | 27. 00 |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0 | 0 | 1 | 0 | 0 | 28. 00 |

89, 401

89, 401

791, 652

215, 585 254, 555

470, 140

508, 209

215, 585 343, 956

559, 541

1, 299, 861

-100, 388

-100, 388

-100, 388

215, 585 243, 568

459, 153

1, 199, 473

29.00

30.00

31.00

32.00

through 27)
FACILITY OVERHEAD
29.00 Facility Costs

31.00

32.00

30.00 Administrative Costs

Total Facility Overhead (sum of lines 29 and

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

| Health Financial Systems | HENRY COUNTY MEMORIAL HOSPITAL | In Lie | u of Form CMS-2552-10 |
|---|--------------------------------|----------------------------|-----------------------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provi der CCN: 15-0030 | Period: From 01/01/2021 | Worksheet M-1 |
| | Component CCN: 15-8556 | | Date/Time Prepared: |

| | | | Component | CCN: 15-8556 | То | 12/31/2021 | Date/Time Pro 5/26/2022 3: | |
|--------|--|---|--------------|--------------|----|------------|----------------------------|--------|
| | | | | | | RHC III | Cost | |
| | | Adjustments | Net Expenses | | | | | |
| | | | for | | | | | |
| | | | Allocation | | | | | |
| | | | (col. 5 + | | | | | |
| | | | col. 6) | | | | | |
| | | 6. 00 | 7.00 | | | | | |
| | FACILITY HEALTH CARE STAFF COSTS | | | | | | | |
| 1.00 | Physi ci an | 0 | 271, 22 | 3 | | | | 1.00 |
| 2.00 | Physician Assistant | 0 | (| 0 | | | | 2.00 |
| 3.00 | Nurse Practitioner | 0 | 260, 68 | 5 | | | | 3.00 |
| 4.00 | Visiting Nurse | 0 | (| 0 | | | | 4. 00 |
| 5.00 | Other Nurse | 0 | 71, 44 | 3 | | | | 5. 00 |
| 6.00 | Clinical Psychologist | 0 | (| 0 | | | | 6. 00 |
| 7.00 | Clinical Social Worker | 0 | | 0 | | | | 7. 00 |
| 8.00 | Laboratory Techni ci an | 0 | | 0 | | | | 8. 00 |
| 9.00 | Other Facility Health Care Staff Costs | 0 | 104, 84 | 6 | | | | 9. 00 |
| 10.00 | Subtotal (sum of lines 1 through 9) | 0 | 708, 19 | 7 | | | | 10.00 |
| 11.00 | Physician Services Under Agreement | 0 | | ol | | | | 11.00 |
| 12.00 | Physician Supervision Under Agreement | 0 | (| ol | | | | 12.00 |
| 13.00 | Other Costs Under Agreement | 0 | (| ol | | | | 13.00 |
| 14.00 | Subtotal (sum of lines 11 through 13) | 0 | (| ol | | | | 14.00 |
| 15.00 | Medical Supplies | o | 32, 12 | 3 | | | | 15.00 |
| 16.00 | Transportation (Health Care Staff) | o | | ol | | | | 16.00 |
| 17.00 | Depreciation-Medical Equipment | o | (| ol | | | | 17. 00 |
| 18. 00 | Professional Liability Insurance | o | (| ol | | | | 18.00 |
| | Other Health Care Costs | o | (| ol | | | | 19.00 |
| 20.00 | Allowable GME Costs | | | | | | | 20.00 |
| 21. 00 | Subtotal (sum of lines 15 through 20) | o | 32, 12 | 3 | | | | 21.00 |
| 22. 00 | Total Cost of Health Care Services (sum of | o | 740, 32 | • | | | | 22. 00 |
| | lines 10, 14, and 21) | ٦ | , | 1 | | | | |
| | COSTS OTHER THAN RHC/FQHC SERVICES | ' | | · | | | | |
| 23.00 | Pharmacy | 0 | (| 0 | | | | 23. 00 |
| 24.00 | Dental | o | (| ol | | | | 24.00 |
| 25.00 | Optometry | o | (| ol | | | | 25. 00 |
| 25. 01 | Tel eheal th | o | (| ol | | | | 25. 01 |
| 25. 02 | | o | (| ol | | | | 25. 02 |
| 26. 00 | All other nonreimbursable costs | o | (| ol | | | | 26. 00 |
| 27. 00 | Nonallowable GME costs |] | | 1 | | | | 27. 00 |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0 | | ol | | | | 28. 00 |
| | through 27) | ٦ | | 1 | | | | |
| | FACILITY OVERHEAD | I | | | | | | 1 |
| 29. 00 | Facility Costs | -86, 300 | 129, 28 | 5 | | | | 29. 00 |
| 30. 00 | Administrative Costs | -56, 022 | 187, 54 | 1 | | | | 30.00 |
| 31. 00 | Total Facility Overhead (sum of lines 29 and | · . | 316, 83 | 1 | | | | 31.00 |
| 2 20 | 30) | , 522 | 2.2700 | | | | | |
| 32. 00 | Total facility costs (sum of lines 22, 28 | -142, 322 | 1, 057, 15 | 1 | | | | 32.00 |
| | and 31) | , | , , | | | | | |
| | | ı | | ' | | | | |

| near th r | Financial Systems HE | ENRY COUNTY MEM | ORIAL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|-----------|--|------------------|-----------------|----------------|-----------------------------|-----------------------------|---------|
| | ION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S | SERVI CES | Provi der Co | | Peri od: From 01/01/2021 | Worksheet M-2 | |
| | | | Component | CCN: 15-8520 | To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
| | | | | | RHC I | Cost | |
| | | Number of FTE | Total Visits | Producti vi ty | | Greater of | |
| | | Personnel | | Standard (1) | Visits (col. | col. 2 or | |
| | | | | | 1 x col. 3) | col. 4 | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | /ISITS AND PRODUCTIVITY | | | | | | |
| | Positions | 11 | | | | | |
| | Physi ci an | 4. 56 | | | 1 5 | | 1.00 |
| | Physician Assistant | 1. 12 | | | 1 1 | | 2.00 |
| | Nurse Practitioner | 2. 85 | | | 1 3 | | 3.00 |
| | Subtotal (sum of lines 1 through 3) | 8. 53 | | | 9 | 20, 995 | |
| | Visiting Nurse | 0.00 | 0 | | | 0 | 5.00 |
| | Clinical Psychologist | 0.00 | 0 | | | 0 | 6.00 |
| | Clinical Social Worker | 0. 43 | | | | 740 | |
| | Medical Nutrition Therapist (FQHC only) | 0.00 | | | | 0 | |
| | Diabetes Self Management Training (FQHC only) | 0.00 | 0 | | | 0 | 7. 02 |
| | Total FTEs and Visits (sum of lines 4 | 8. 96 | 21, 735 | | | 21, 735 | 8. 00 |
| | through 7) | 0. 70 | 21,733 | | | 21,733 | 0.00 |
| | Physician Services Under Agreements | | 0 | | | 0 | 9. 00 |
| 7. 00 1 | Thysi crair services bluer Agreements | | <u> </u> | | | 0 | 7.00 |
| | | | | | | 1. 00 | |
| Г | DETERMINATION OF ALLOWABLE COST APPLICABLE T | O HOSPI TAL-BASE | ED RHC/FQHC SEF | RVICES | | | |
| 10.00 | Total costs of health care services (from Wk | st. M-1, col. | 7, line 22) | | | 3, 621, 240 | 10.00 |
| 11.00 | Total nonreimbursable costs (from Wkst. M-1, | col. 7, line 2 | 28) | | | 0 | 11.00 |
| 12.00 | Cost of all services (excluding overhead) (s | um of lines 10 | and 11) | | | 3, 621, 240 | 12.00 |
| | Ratio of hospital-based RHC/FQHC services (I | | | | | 1.000000 | 13.00 |
| 14. 00 | Total hospital-based RHC/FQHC overhead - (fr | om Worksheet. M | M-1, col. 7, li | ne 31) | | 1, 862, 409 | 14.00 |
| 15. 00 F | Parent provider overhead allocated to facili | ty (see instruc | ctions) | | | 4, 090, 790 | 15.00 |
| 16.00 | Total overhead (sum of lines 14 and 15) | | | | | 5, 953, 199 | 16.00 |
| 17.00 | Allowable GME overhead (see instructions) | | | | | 0 | |
| | Enter the amount from line 16 | | | | | 5, 953, 199 | |
| | Overhead applicable to hospital-based RHC/FO | | | | | 5, 953, 199 | |
| 20. 00 | Total allowable cost of hospital-based RHC/F | QHC services (s | sum of lines 10 | o and 19) | | 9, 574, 439 | 20.00 |

| Heal th | Financial Systems HI | ENRY COUNTY MEN | MORIAL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|----------------|--|-----------------|-----------------|----------------|----------------------------------|-----------------|---------|
| ALLOC/ | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S | SERVI CES | Provi der C | | Peri od: | Worksheet M-2 | |
| | | | Component | CCN: 15-8525 | From 01/01/2021 To 12/31/2021 | Date/Time Pre | nared: |
| | | | Component | CCN. 13-0323 | 10 12/31/2021 | 5/26/2022 3: 4 | |
| | | | | | RHC II | Cost | |
| | | Number of FTE | Total Visits | Producti vi ty | | Greater of | |
| | | Personnel | | Standard (1) | | col. 2 or | |
| | | | | | 1 x col. 3) | col. 4 | |
| | hu ou To AND DDODUGTINU TV | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| | VISITS AND PRODUCTIVITY | | | | | | 1 |
| 1 00 | Positions Dhysician | 8.09 | 24.705 | T | 1 0 | | 1.00 |
| 1. 00 2. 00 | Physi ci an Physi ci an Assi stant | 0.00 | | | 1 8 | | 2.00 |
| 3.00 | Nurse Practitioner | 13. 01 | | | 1 13 | | 3.00 |
| 4. 00 | Subtotal (sum of lines 1 through 3) | 21. 10 | | | 21 | 48, 491 | 4.00 |
| 5. 00 | Visiting Nurse | 0.00 | | 1 | 21 | 40, 471 | |
| 6. 00 | Clinical Psychologist | 0.00 | | • | | 0 | |
| 7. 00 | Clinical Social Worker | 0. 21 | | | | 230 | |
| 7. 01 | Medical Nutrition Therapist (FQHC only) | 0.00 | | | | 0 | 1 |
| 7. 02 | Diabetes Self Management Training (FQHC | 0.00 | 0 | | | 0 | 7. 02 |
| | onl y) | | | | | | |
| 8.00 | Total FTEs and Visits (sum of lines 4 | 21. 31 | 48, 721 | | | 48, 721 | 8. 00 |
| | through 7) | | | | | | |
| 9. 00 | Physician Services Under Agreements | | 0 | | | 0 | 9.00 |
| | | | | | | 1 00 | |
| | DETERMINATION OF ALLOWARIE COST APPLICABLE T | O HOCDLEAL DAC | ED DUC/FOUR CEI | DVII CEC | | 1. 00 | |
| 10 00 | DETERMINATION OF ALLOWABLE COST APPLICABLE T Total costs of health care services (from Wk | | | RVICES | | 6, 801, 239 | 10.00 |
| 11. 00 | Total nonreimbursable costs (from Wkst. M-1, | | | | | 0, 801, 239 | 1 |
| 12.00 | Cost of all services (excluding overhead) (s | | | | | 6, 801, 239 | |
| 13. 00 | Ratio of hospital-based RHC/FQHC services (I | | | | | 1. 000000 | |
| 14. 00 | Total hospital -based RHC/FQHC overhead - (fr | | | ine 31) | | 2, 396, 910 | |
| 15. 00 | | | | | | 7, 676, 922 | |
| 16.00 | Total overhead (sum of lines 14 and 15) | ., (**** | , | | | 10, 073, 832 | |
| 17.00 | Allowable GME overhead (see instructions) | | | | | 0 | 17. 00 |
| 18.00 | Enter the amount from line 16 | | | | | 10, 073, 832 | 18. 00 |
| | Overhead applicable to hospital-based RHC/FC | | | | | 10, 073, 832 | |
| 20.00 | Total allowable cost of hospital-based RHC/F | FQHC services (| sum of lines 1 | 0 and 19) | | 16, 875, 071 | 20.00 |

| Heal th | Financial Systems HI | ENRY COUNTY MEN | MORIAL HOSPITAL | <u>-</u> | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|-----------------|-----------------|----------------|----------------------------------|--------------------------------|---------|
| ALLOCA | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S | SERVI CES | Provi der C | | Peri od: | Worksheet M-2 | |
| | | | Component | | From 01/01/2021 To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
| | | | | | RHC III | Cost | • |
| | | Number of FTE | Total Visits | Producti vi ty | | Greater of | |
| | | Personnel | | Standard (1) | Visits (col. | col. 2 or | |
| | | | | | 1 x col. 3) | col. 4 | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | VISITS AND PRODUCTIVITY | | | | | | |
| | Posi ti ons | _ | | | | | |
| 1. 00 | Physi ci an | 0. 60 | | | 1 1 | | 1.00 |
| 2.00 | Physician Assistant | 0. 17 | | 1 | 1 0 | | 2.00 |
| 3.00 | Nurse Practitioner | 1. 61 | | | 1 2 | | 3.00 |
| 4.00 | Subtotal (sum of lines 1 through 3) | 2. 38 | | | 3 | 4, 664 | |
| 5.00 | Visiting Nurse | 0.00 | | | | 0 | |
| 6. 00 | Clinical Psychologist | 0.00 | | 1 | | 0 | 6.00 |
| 7.00 | Clinical Social Worker | 0.00 | l . | | | 0 | 7.00 |
| 7. 01 | Medical Nutrition Therapist (FQHC only) | 0.00 | | | | 0 | |
| 7. 02 | Diabetes Self Management Training (FQHC | 0.00 | 0 |) | | 0 | 7. 02 |
| | onl y) | | | | | | |
| 8. 00 | Total FTEs and Visits (sum of lines 4 | 2. 38 | 4, 664 | | | 4, 664 | 8. 00 |
| | through 7) | | | | | | |
| 9. 00 | Physician Services Under Agreements | | 0 | | | 0 | 9. 00 |
| | | | | | | 1. 00 | |
| | DETERMINATION OF ALLOWABLE COST APPLICABLE T | O HUSDITAI BASI | ED BUC/EDUC SEI | DVI CES | | 1.00 | |
| | Total costs of health care services (from Wk | | | KVICLS | | 740, 320 | 10 00 |
| 11. 00 | Total nonreimbursable costs (from Wkst. M-1, | | | | | 740, 320 | |
| 12.00 | Cost of all services (excluding overhead) (s | | | | | 740, 320 | |
| 13.00 | Ratio of hospital-based RHC/FQHC services (I | | | | | 1. 000000 | |
| 14. 00 | Total hospital-based RHC/FQHC overhead - (fr | | | ine 31) | | 316, 831 | |
| 15. 00 | Parent provider overhead allocated to facili | | | THE ST) | | 807, 564 | |
| 16. 00 | Total overhead (sum of lines 14 and 15) | ty (see mistru | Cti ons) | | | 1, 124, 395 | |
| 17. 00 | Allowable GME overhead (see instructions) | | | | | 1, 124, 373 | 1 |
| | Enter the amount from line 16 | | | | | 1, 124, 395 | |
| | Overhead applicable to hospital-based RHC/FC | HC services (| ine 13 x line | 18) | | 1, 124, 395 | |
| | Total allowable cost of hospital based RHC/F | | | | | 1, 864, 715 | |
| _0.00 | 1. Sta. a Shabi o cost of hospital based kno/i | Z 301 V1 003 (| Ja 01 111103 1 | 5 a.ia 17) | | 1, 551, 715 | 0.00 |

| Hool +h | Financial Systems HENRY COUNTY MEMORI | AL LICONITAL | In Lio | u of Form CMS 1 | DEE2 10 |
|------------------|---|--------------------------|----------------------------------|----------------------------------|------------------|
| | Financial Systems HENRY COUNTY MEMORI ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC | | Peri od: | u of Form CMS-2 Worksheet M-3 | |
| SERVI C | CES | Component CCN: 15-8520 | From 01/01/2021 To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
| | | Title XVIII | RHC I | Cost | <u> </u> |
| | | | | 4.00 | |
| | DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES | | | 1. 00 | |
| 1.00 | Total Allowable Cost of hospital-based RHC/FQHC Services (fro | om Wkst. M-2, line 20) | | 9, 574, 439 | 1.00 |
| 2.00 | Cost of injections/infusions and their administration (from W | /kst. M-4, line 15) | | 205, 555 | 2.00 |
| 3.00 | Total allowable cost excluding injections/infusions (line 1 m | ninus line 2) | | 9, 368, 884 | 3.00 |
| 4.00 | Total Visits (from Wkst. M-2, column 5, line 8) | 1: 20 0) | | 21, 735 | 4.00 |
| 5. 00 6. 00 | Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5) | 11 ne 9) | | 0 21, 735 | 5. 00 6. 00 |
| 7. 00 | Adjusted cost per visit (line 3 divided by line 6) | | | 431.05 | 7.00 |
| | | | Cal cul ati on | | |
| | | | D 1 D 1 1 1 | | |
| | | | (01/01/2021 | Rate Period 2 (04/01/2021 | |
| | | | through | through | |
| | | | 03/31/2021) | 12/31/2021) | |
| | T | | 1.00 | 2. 00 | |
| 8.00 | Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 | 0.6 or your contractor) | 0.00 | 411. 33 | |
| 9. 00 | Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT | | 431. 05 | 411. 33 | 9. 00 |
| 10.00 | Program covered visits excluding mental health services (from | contractor records) | 1, 426 | 4, 550 | 10.00 |
| 11.00 | Program cost excluding costs for mental health services (line | | 614, 677 | 1, 871, 552 | • |
| 12.00 | Program covered visits for mental health services (from contr | * | 0 | 0 | |
| 13.00 | Program covered cost from mental health services (line 9 x li | • | 0 | 0 | 13.00 |
| 14. 00 15. 00 | Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instruction | | 0 | 0 | 14. 00 15. 00 |
| 16. 00 | Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 | , | 0 | 2, 486, 229 | |
| 16. 01 | Total program charges (see instructions)(from contractor's re | • | | 1, 087, 124 | |
| 16. 02 | Total program preventive charges (see instructions)(from prov | • | | 157, 394 | |
| 16. 03 | Total program preventive costs ((line 16.02/line 16.01) times | * | | 359, 956 | |
| 16. 04 | Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.) | 3 and 18) times .80) | | 1, 625, 725 | 16. 04 |
| 16. 05 | Total program cost (see instructions) | | 0 | 1, 985, 681 | 16. 05 |
| 17.00 | Primary payer amounts | | | 0 | 17. 00 |
| 18. 00 | Less: Beneficiary deductible for RHC only (see instructions) | (from contractor | | 94, 117 | 18. 00 |
| 10.00 | records) | una) (from contractor | | 1/7 100 | 10.00 |
| 19. 00 | Beneficiary coinsurance for RHC/FQHC services (see instruction records) | ons) (from contractor | | 167, 123 | 19. 00 |
| 20.00 | Net Medicare cost excluding vaccines (see instructions) | | | 1, 985, 681 | 20.00 |
| 21.00 | Program cost of vaccines and their administration (from Wkst. | M-4, line 16) | | 66, 906 | 21.00 |
| 22. 00 | | | | 2, 052, 587 | 22.00 |
| 23. 00 23. 01 | Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) | | | 0 | 23. 00 23. 01 |
| 24. 00 | 1 3 | ructions) | | 0 | |
| | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | 401. 66) | | 0 | |
| 25. 50 | Pioneer ACO demonstration payment adjustment (see instruction | ıs) | | 0 | 25. 50 |
| 25. 99 | | | | 0 | |
| 26. 00 26. 01 | Net reimbursable amount (see instructions) | | | 2, 052, 587 0 | 26. 00 26. 01 |
| 26. 02 | | | | 0 | 26. 02 |
| 27. 00 | , | | | 1, 869, 182 | |
| | Tentative settlement (for contractor use only) | | | 0 | 28. 00 |
| 29.00 | Balance due component/program (line 26 minus lines 26.01, 26. | • | | 183, 405 | • |
| 30. 00 | Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2 | ince with CMS Pub. 15-II | ' | 0 | 30.00 |
| | Onaptor 1, 3110.2 | | I | ı | ı |

| <u> </u> | I AL HOSPI TAL | | u of Form CMS-2 | |
|--|--------------------------|-----------------------------|-------------------------|----------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC | Provider CCN: 15-0030 | Peri od: From 01/01/2021 | Worksheet M-3 | |
| SERVI CES | Component CCN: 15-8525 | To 12/31/2021 | Date/Time Pre | pared: |
| | · | | 5/26/2022 3: 4 | |
| | Title XVIII | RHC II | Cost | |
| | | | 1. 00 | |
| DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES | | | | |
| .00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro | om Wkst. M-2, line 20) | | 16, 875, 071 | 1.00 |
| 2.00 Cost of injections/infusions and their administration (from N | | | 1, 324, 614 | 2.00 |
| 3.00 Total allowable cost excluding injections/infusions (line 1 r | minus line 2) | | 15, 550, 457 | 3.00 |
| I.00 Total Visits (from Wkst. M-2, column 5, line 8) | 11 0) | | 48, 721 | 4.00 |
| 5.00 Physicians visits under agreement (from Wkst. M-2, column 5, 5.00 Total adjusted visits (line 4 plus line 5) | Time 9) | | 0 48, 721 | 5. 00 6. 00 |
| 7.00 Adjusted cost per visit (line 3 divided by line 6) | | | 319. 17 | |
| . oo naj usteu eest per visit (iiile s arvidea by iiile s | | Cal cul ati on | of Limit (1) | 7.00 |
| | | our our a troir | 0. 2 (1) | |
| | | Rate Period 1 | | |
| | | (01/01/2021 | (04/01/2021 | |
| | | through | through | |
| | | 03/31/2021) | 12/31/2021) 2. 00 | |
| 8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 |) 6 or your contractor) | 0.00 | 300. 17 | 8.00 |
| 2.00 Rate for Program covered visits (see instructions) | 5. 0 c. you. co acto.) | 319. 17 | 300. 17 | 9.00 |
| CALCULATION OF SETTLEMENT | | | | |
| 0.00 Program covered visits excluding mental health services (from | | 1, 694 | 5, 282 | |
| 1.00 Program cost excluding costs for mental health services (line | | 540, 674 | 1, 585, 498 | |
| 2.00 Program covered visits for mental health services (from conti | , | 0 | 0 | |
| 3.00 Program covered cost from mental health services (line 9 x li 4.00 Limit adjustment for mental health services (see instructions | * | 0 | 0 | 13.00 14.00 |
| 4.00 Limit adjustment for mental health services (see instructions 5.00 Graduate Medical Education Pass Through Cost (see instructions | | U | U | 15.00 |
| 6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 | | 0 | 2, 126, 172 | |
| 6.01 Total program charges (see instructions) (from contractor's re | • | | 1, 446, 758 | |
| 6.02 Total program preventive charges (see instructions) (from prov | vi der's records) | | 363, 057 | 16. 02 |
| 6.03 Total program preventive costs ((line 16.02/line 16.01) times | | | 533, 552 | |
| 6.04 Total Program non-preventive costs ((line 16 minus lines 16.0 | 03 and 18) times .80) | | 1, 148, 522 | 16. 04 |
| (Titles V and XIX see instructions.) | | | 1 402 074 | 14 05 |
| 6.05 Total program cost (see instructions) 7.00 Primary payer amounts | | 0 | 1, 682, 074 0 | |
| 8.00 Less: Beneficiary deductible for RHC only (see instructions) |) (from contractor | | 156, 968 | |
| records) | , (| | 100, 700 | |
| 9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction | ons) (from contractor | | 185, 317 | 19.00 |
| records) | | | | |
| 20.00 Net Medicare cost excluding vaccines (see instructions) | W 4 - 12 - 240 | | 1, 682, 074 | |
| 21.00 Program cost of vaccines and their administration (from Wkst. 22.00 Total reimbursable Program cost (line 20 plus line 21) | M-4, IINe 16) | | 185, 036 1, 867, 110 | |
| 23.00 Allowable bad debts (see instructions) | | | 1, 867, 110 | 1 |
| 23. 01 Adjusted reimbursable bad debts (see instructions) | | | Ö | 1 |
| 24.00 Allowable bad debts for dual eligible beneficiaries (see ins | tructions) | | 0 | |
| 25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | 25.00 |
| 25.50 Pioneer ACO demonstration payment adjustment (see instruction | ns) | | 0 | |
| 25.99 Demonstration payment adjustment amount before sequestration | | | 0 | |
| 26.00 Net reimbursable amount (see instructions) | | | 1, 867, 110 | 1 |
| 26.01 Sequestration adjustment (see instructions) 26.02 Demonstration payment adjustment amount after sequestration | | | 0 | |
| 27.00 Interim payments | | | 1, 541, 236 | |
| 28.00 Tentative settlement (for contractor use only) | | | 1, 541, 230 | 28.00 |
| 29.00 Balance due component/program (line 26 minus lines 26.01, 26. | 02, 27, and 28) | | 325, 874 | |
| 30.00 Protested amounts (nonallowable cost report items) in accorda | ance with CMS Pub. 15-II | , | 0 | 1 |
| chapter I, §115.2 | | 1 | | l |

| CALCULATION | cial Systems HENRY COUNTY MEMORI OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC | | Peri od: | u of Form CMS-2 Worksheet M-3 | |
|------------------------|--|---------------------------------------|------------------------|----------------------------------|--------------|
| SERVI CES | | Component CCN: 15-8556 | From 01/01/2021 | Date/Time Pre | narad |
| | | Component Con: 15-8556 | To 12/31/2021 | 5/26/2022 3: 4 | |
| | | Title XVIII | RHC III | Cost | |
| | | | | 1. 00 | |
| DETERM | INATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES | | | 1.00 | |
| | Allowable Cost of hospital-based RHC/FQHC Services (fro | om Wkst. M-2, line 20) | | 1, 864, 715 | 1.0 |
| 1 | of injections/infusions and their administration (from W | | | 24, 802 | |
| | allowable cost excluding injections/infusions (line 1 m | ninus line 2) | | 1, 839, 913 | 1 |
| 1 | Visits (from Wkst. M-2, column 5, line 8) | 11 0) | | 4, 664 | |
| | cians visits under agreement (from Wkst. M-2, column 5, adjusted visits (line 4 plus line 5) | Tine 9) | | 0 4. 664 | 5. 0 6. 0 |
| | ted cost per visit (line 3 divided by line 6) | | | 394. 49 | 1 |
| . co naj as | ca cost per visit (iiiie o dividea by iiiie o) | | Cal cul ati on | | 7.0 |
| | | | | | |
| | | | Rate Peri od 1 | | |
| | | | (01/01/2021 through | (04/01/2021 | |
| | | | through 03/31/2021) | through 12/31/2021) | |
| | | | 1.00 | 2.00 | |
| 3.00 Per vi | sit payment limit (from CMS Pub. 100-04, chapter 9, §20 | 0.6 or your contractor) | 0.00 | 406. 02 | 8.0 |
| | for Program covered visits (see instructions) | | 394. 49 | 394. 49 | 9.0 |
| | ATION OF SETTLEMENT | | 10/ | 710 | 1 10 0 |
| | am covered visits excluding mental health services (from am cost excluding costs for mental health services (line | | 186 73, 375 | 710 280, 088 | 1 |
| , , | am covered visits for mental health services (from contr | * | 73, 373 | 280, 088 | 1 |
| 1 0 | am covered cost from mental health services (line 9 x li | • | 0 | 0 | 1 |
| , , | adjustment for mental health services (see instructions | | 0 | 0 | 1 |
| 5.00 Gradua | ate Medical Education Pass Through Cost (see instruction | is) | | | 15.0 |
| | Program cost (sum of lines 11, 14, and 15, columns 1, 2 | | 0 | 353, 463 | 1 |
| | program charges (see instructions)(from contractor's re | • | | 155, 800 | |
| | program preventive charges (see instructions)(from prov program preventive costs ((line 16.02/line 16.01) times | | | 34, 392 78, 025 | |
| 1 | Program non-preventive costs ((Time 10.02/Time 10.01) times | • | | 210, 353 | |
| | es V and XIX see instructions.) | or und roy trines . co) | | 210,000 | 10. 0 |
| | program cost (see instructions) | | 0 | 288, 378 | 16.0 |
| | ry payer amounts | | | 25 | |
| | Beneficiary deductible for RHC only (see instructions) | (from contractor | | 12, 497 | 18.0 |
| record 19.00 Benefi | ds) ciary coinsurance for RHC/FQHC services (see instructio | ons) (from contractor | | 21 702 | 19.0 |
| record | · · | ons) (IT on Contractor | | 21, 782 | 19.0 |
| | edicare cost excluding vaccines (see instructions) | | | 288, 353 | 20.0 |
| 1.00 Progra | am cost of vaccines and their administration (from Wkst. | M-4, line 16) | | 7, 977 | 21.0 |
| | reimbursable Program cost (line 20 plus line 21) | | | 296, 330 | 1 |
| 1 | able bad debts (see instructions) | | | 0 | |
| 1 - | red reimbursable bad debts (see instructions) | | | 0 | |
| | able bad debts for dual eligible beneficiaries (see inst ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | .ructions) | | 0 | |
| | er ACO demonstration payment adjustment (see instruction | ns) | | 0 | |
| | stration payment adjustment amount before sequestration | / | | 0 | 1 |
| | eimbursable amount (see instructions) | | | 296, 330 | 1 |
| 6. 01 Seques | stration adjustment (see instructions) | | | 0 | 26. (|
| | stration payment adjustment amount after sequestration | | | 0 | |
| 7.00 Interi | | | | 262, 902 | |
| | ive settlement (for contractor use only) | 02 27 and 20) | | 0 | 28.0 |
| 1 | ce due component/program (line 26 minus lines 26.01, 26. Sted amounts (nonallowable cost report items) in accorda | · · · · · · · · · · · · · · · · · · · | | 33, 428 0 | 1 |
| .o. oo pri otes | er I, §115.2 | inco wi tii owa rub. 10-11 | ' | U | ا ٥٠٠٠ |

| | Financial Systems HENRY COUNTY MEN | | | | u of Form CMS-2 | |
|--------|--|--------------|--------------|----------------------------------|-----------------|--------|
| COMPUT | ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST | Provi der Co | | Peri od: | Worksheet M-4 | |
| | | Component (| | From 01/01/2021 To 12/31/2021 | Date/Time Pre | narad. |
| | | Component | CCN: 15-8520 | To 12/31/2021 | 5/26/2022 3: 4 | |
| | | Title | XVIII | RHC I | Cost | о рііі |
| | | PNEUMOCOCCAL | INFLUENZA | COVI D-19 | MONOCLONAL | |
| | | VACCINES | VACCI NES | VACCINES | ANTI BODY | |
| | | | | | PRODUCTS | |
| | | 1.00 | 2. 00 | 2. 01 | 2. 02 | |
| 1. 00 | Health care staff cost (from Wkst. M-1, col. 7, line 10) | 3, 466, 537 | 3, 466, 53 | 7 3, 466, 537 | 3, 466, 537 | 1.00 |
| 2.00 | Ratio of injection/infusion staff time to total health | 0. 000265 | 0. 00236 | 0.000000 | 0.000000 | 2.00 |
| | care staff time | | | | | |
| 3.00 | Injection/infusion health care staff cost (line 1 x line | 919 | 8, 18 | 4 0 | 0 | 3.00 |
| | 2) | | | | | |
| 4.00 | Injections/infusions and related medical supplies costs | 16, 758 | 51, 88 | 4 0 | 0 | 4. 00 |
| | (from your records) | | | | | |
| 5.00 | Direct cost of injections/infusions (line 3 plus line 4) | 17, 677 | 60, 06 | 8 0 | 0 | 5.00 |
| 6.00 | Total direct cost of the hospital-based RHC/FQHC (from | 3, 621, 240 | 3, 621, 24 | 3, 621, 240 | 3, 621, 240 | 6.00 |
| | Worksheet M-1, col. 7, line 22) | | | | | |
| 7.00 | Total overhead (from Wkst. M-2, line 19) | 5, 953, 199 | 5, 953, 19 | 9 5, 953, 199 | 5, 953, 199 | 7. 00 |
| 8.00 | Ratio of injection/infusion direct cost to total direct | 0. 004881 | 0. 01658 | 0. 000000 | 0. 000000 | 8. 00 |
| | cost (line 5 divided by line 6) | | | | | |
| 9.00 | Overhead cost - injection/infusion (line 7 x line 8) | 29, 058 | 98, 75 | 2 0 | 0 | 9. 00 |
| 10.00 | Total injection/infusion costs and their administration | 46, 735 | 158, 82 | 0 | 0 | 10.00 |
| | costs (sum of lines 5 and 9) | | | | | |
| 11. 00 | Total number of injections/infusions (from your records) | 98 | 87 | | 0 | 11. 00 |
| 12.00 | Cost per injection/infusion (line 10/line 11) | 476. 89 | 182. 1 | 0.00 | 0.00 | 12.00 |
| 13.00 | Number of injection/infusion administered to Program | 41 | 26 | 0 | 0 | 13.00 |
| | benefi ci ari es | | | | | |
| 13. 01 | Number of COVID-19 vaccine injections/infusions | | | 0 | 0 | 13. 01 |
| | administered to MA enrollees | | | | | |
| 14.00 | Program cost of injections/infusions and their | 19, 552 | 47, 35 | 4 0 | 0 | 14.00 |

205, 555

66, 906

15.00

16.00

administration costs (line 12 times the sum of lines 13

administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)

15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)

16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

| Heal th | Financial Systems HENRY COUNTY MEM | MORIAL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|---|---------------------------|-------------------------|----------------------------------|-------------------------------------|---------|
| | ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST | Provi der CO | CN: 15-0030 | Peri od: | Worksheet M-4 | |
| | | Component (| | From 01/01/2021 To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
| | | Title | XVIII | RHC II | Cost | |
| | | PNEUMOCOCCAL VACCI NES | I NFLUENZA VACCI NES | COVI D-19 VACCI NES | MONOCLONAL ANTI BODY PRODUCTS | |
| | | 1.00 | 2. 00 | 2. 01 | 2. 02 | |
| 1.00 | Health care staff cost (from Wkst. M-1, col. 7, line 10) | 6, 373, 828 | 6, 373, 82 | | | 1.00 |
| 2. 00 | Ratio of injection/infusion staff time to total health care staff time | 0. 002137 | 0. 00354 | 0. 001529 | 0.000000 | 2. 00 |
| 3. 00 | <pre>Injection/infusion health care staff cost (line 1 x line 2)</pre> | 13, 621 | 22, 60. | 9, 746 | 0 | 3. 00 |
| 4. 00 | Injections/infusions and related medical supplies costs (from your records) | 309, 339 | 178, 56 | 0 | 0 | 4. 00 |
| 5.00 | Direct cost of injections/infusions (line 3 plus line 4) | 322, 960 | 201, 16 | 9, 746 | 0 | 5.00 |
| 6. 00 | Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) | 6, 801, 239 | 6, 801, 23 | 6, 801, 239 | 6, 801, 239 | 6. 00 |
| 7.00 | Total overhead (from Wkst. M-2, line 19) | 10, 073, 832 | 10, 073, 83 | 10, 073, 832 | 10, 073, 832 | 7.00 |
| 8. 00 | Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6) | 0. 047485 | 0. 02957 | 0. 001433 | 0. 000000 | 8. 00 |
| 9.00 | Overhead cost - injection/infusion (line 7 x line 8) | 478, 356 | 297, 95 | 14, 436 | 0 | 9.00 |
| 10. 00 | Total injection/infusion costs and their administration costs (sum of lines 5 and 9) | 801, 316 | 499, 11 | 24, 182 | 0 | 10.00 |
| 11.00 | Total number of injections/infusions (from your records) | 1, 809 | 3, 00 | 1, 294 | 0 | 11.00 |
| 12.00 | Cost per injection/infusion (line 10/line 11) | 442. 96 | 166. 3 | 18. 69 | 0.00 | 12.00 |
| 13. 00 | Number of injection/infusion administered to Program beneficiaries | 202 | 54 | 254 | 0 | 13. 00 |
| 13. 01 | Number of COVID-19 vaccine injections/infusions administered to MA enrollees | | | 0 | 0 | 13. 01 |
| 14. 00 | Program cost of injections/infusions and their | 89, 478 | 90, 81 | 4, 747 | О | 14. 00 |

administration costs (line 12 times the sum of lines 13

and 13.01, as applicable)

15.00

Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)

16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

1, 324, 614

185, 036

15.00

16.00

| Health Financial Systems | HENRY COUNTY MEMORI | IAL HOSPITAL | In Lieu | u of Form CMS-2552-10 |
|--|---------------------|------------------------|-----------------------------|-----------------------|
| COMPUTATION OF HOSPITAL-BASED RHC/FQHC | VACCINE COST | Provi der CCN: 15-0030 | Peri od: From 01/01/2021 | Worksheet M-4 |
| | | Component CCN: 15-8556 | | |
| | | Ti +1 o V/// / / | DUC III | Cost |

| | | Component (| CCN: 15-8556 | From 01/01/2021 To 12/31/2021 | Date/Time Pre 5/26/2022 3:4 | |
|--------|--|---------------------------|-------------------------|----------------------------------|-------------------------------------|--------|
| | | Title | XVIII | RHC III | Cost | |
| | | PNEUMOCOCCAL VACCI NES | I NFLUENZA VACCI NES | COVI D-19 VACCI NES | MONOCLONAL ANTI BODY PRODUCTS | |
| | | 1.00 | 2. 00 | 2. 01 | 2. 02 | |
| 1.00 | Health care staff cost (from Wkst. M-1, col. 7, line 10) | 708, 197 | | | 708, 197 | 1.00 |
| 2. 00 | Ratio of injection/infusion staff time to total health care staff time | 0. 000251 | 0. 00132 | 0. 000000 | 0.000000 | 2. 00 |
| 3. 00 | Injection/infusion health care staff cost (line 1 x line 2) | 178 | 93 | 0 | 0 | 3.00 |
| 4. 00 | Injections/infusions and related medical supplies costs (from your records) | 3, 078 | 5, 65 | 0 | 0 | 4. 00 |
| 5.00 | Direct cost of injections/infusions (line 3 plus line 4) | 3, 256 | 6, 59 | 0 0 | 0 | 5.00 |
| 6. 00 | Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) | 740, 320 | 740, 32 | 740, 320 | 740, 320 | 6. 00 |
| 7.00 | Total overhead (from Wkst. M-2, line 19) | 1, 124, 395 | 1, 124, 39 | 1, 124, 395 | 1, 124, 395 | 7.00 |
| 8. 00 | Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6) | 0. 004398 | 0. 00890 | 0. 000000 | 0.000000 | 8. 00 |
| 9.00 | Overhead cost - injection/infusion (line 7 x line 8) | 4, 945 | 10, 01 | 0 | 0 | 9. 00 |
| 10. 00 | Total injection/infusion costs and their administration costs (sum of lines 5 and 9) | 8, 201 | 16, 60 | 0 | 0 | 10. 00 |
| 11.00 | Total number of injections/infusions (from your records) | 18 | ç | 0 0 | 0 | 11.00 |
| 12.00 | Cost per injection/infusion (line 10/line 11) | 455. 61 | 174. 7 | 75 0.00 | 0.00 | 12.00 |
| 13. 00 | Number of injection/infusion administered to Program beneficiaries | 6 | 3 | 0 | 0 | 13.00 |
| 13. 01 | Number of COVID-19 vaccine injections/infusions administered to MA enrollees | | | 0 | 0 | 13. 01 |
| 14. 00 | Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) | 2, 734 | 5, 24 | 0 | 0 | 14. 00 |
| 15. 00 | Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, | | 24, 80 | 02 | | 15. 00 |
| 16. 00 | line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21) | | 7, 97 | 77 | | 16. 00 |

| Health Financial Systems | HENRY COUNTY MEMORI | AL HOSPITAL | In Lieu | u of Form CMS-2552-10 |
|--|---------------------|------------------------|-----------------------------|---------------------------------------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQH | C PROVIDER FOR | Provider CCN: 15-0030 | Peri od: From 01/01/2021 | Worksheet M-5 |
| SERVICES RENDERED TO FROM MINDERELL OF ART ES | | Component CCN: 15-8520 | To 12/31/2021 | Date/Time Prepared: 5/26/2022 3:43 pm |
| | | | RHC I | Cost |

| | | component con. 13-8320 | 10 12/31/2021 | 5/26/2022 3: 43 | |
|----|--|-----------------------------|---------------|-----------------|----|
| | | | RHC I | Cost | - |
| | | | Par | t B | |
| | | | mm/dd/yyyy | Amount | |
| | | | 1. 00 | 2.00 | |
| 00 | Total interim payments paid to hospital-based RHC/FQHC | | | 1, 338, 082 | 1. |
| 00 | Interim payments payable on individual bills, either submit | ted or to be submitted to | | o | 2. |
| | the contractor for services rendered in the cost reporting | | | | |
| | "NONE" or enter a zero | | | | |
| 00 | List separately each retroactive lump sum adjustment amount | based on subsequent | | | 3 |
| | revision of the interim rate for the cost reporting period. | Also show date of each | | | |
| | payment. If none, write "NONE" or enter a zero. (1) | | | | |
| | Program to Provider | | | | |
| 01 | | | 12/01/2021 | 531, 100 | 3 |
|)2 | | | | 0 | 3 |
|)3 | | | | 0 | 3 |
| 04 | | | | 0 | 3 |
| 05 | | | | 0 | 3 |
| | Provider to Program | | | | |
| 50 | | | | 0 | 3 |
| 51 | | | | 0 | 3 |
| 52 | | | | 0 | 3 |
| 53 | | | | 0 | 3 |
| 54 | | | | 0 | 3 |
| 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3. | | | 531, 100 | 3 |
| 00 | Total interim payments (sum of lines 1, 2, and 3.99) (trans | fer to Worksheet M-3, line | : | 1, 869, 182 | 4 |
| | 27) | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | | | _ |
| 00 | List separately each tentative settlement payment after des | sk review. Also show date o | 1 | | 5 |
| | each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | |
| 01 | Program to Provider | | | 0 | 5 |
|)2 | | | | | E |
|)3 | | | | | 5 |
| | Provider to Program | | | | |
| 50 | 110videi to 110gidiii | | | 0 | 5 |
| 51 | | | | 0 | 5 |
| 52 | | | | ol | 5 |
| 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. | 98) | | l ol | 5 |
| 00 | Determined net settlement amount (balance due) based on the | | | | 6 |
| 01 | SETTLEMENT TO PROVIDER | | | 183, 405 | 6 |
|)2 | SETTLEMENT TO PROGRAM | | | 0 | 6 |
| 00 | Total Medicare program liability (see instructions) | | | 2, 052, 587 | 7 |
| | | | Contractor | NPR Date | |
| | | | Number | (Mo/Day/Yr) | |
| | | 0 | 1. 00 | 2.00 | |
| 00 | Name of Contractor | | | | 8 |

| Health Financial Systems | HENRY COUNTY MEMORI | AL HOSPITAL | In Lieu | u of Form CMS-2 | 2552-10 |
|--|---------------------|------------------------|-----------------------------|-----------------|---------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR | | Provider CCN: 15-0030 | Peri od: From 01/01/2021 | Worksheet M-5 | |
| SERVICES RENDERED TO TROUBAN DENETTOTAL | KI LO | Component CCN: 15-8525 | | | |
| | | | RHC II | Cost | |
| | | | Don | + D | |

| | | Component CCN. 13-0323 | 10 12/31/2021 | 5/26/2022 3: 43 | |
|----------|---|------------------------------|----------------|---------------------|----|
| | | | RHC II | Cost | - |
| | | | Par | t B | |
| | | | mm/dd/yyyy | Amount | |
| | | | 1. 00 | 2.00 | |
| 00 | Total interim payments paid to hospital-based RHC/FQHC | | | 1, 347, 736 | 1. |
| 00 | Interim payments payable on individual bills, either submit | ted or to be submitted to | | 0 | 2. |
| | the contractor for services rendered in the cost reporting | | | | |
| | "NONE" or enter a zero | | | | |
| 00 | List separately each retroactive lump sum adjustment amount | : based on subsequent | | | 3. |
| | revision of the interim rate for the cost reporting period. | Also show date of each | | | |
| | payment. If none, write "NONE" or enter a zero. (1) | | | | |
| | Program to Provider | | | | |
| 01 | | | 12/01/2021 | 193, 500 | 3 |
| 02 | | | | 0 | 3 |
| 03 | | | | 0 | 3 |
| 04 | | | | 0 | 3 |
| 05 | | | | 0 | 3 |
| | Provider to Program | | | | |
| 50 | | | | 0 | 3 |
| 51 | | | | 0 | 3 |
| 52 | | | | 0 | 3 |
| 53 | | | | 0 | 3 |
| 54 99 | | 00) | | 0 193, 500 | 3 |
| 99 00 | Total interim payments (sum of lines 1, 2, and 3.99) (trans | | | | 4 |
| 00 | 27) | ster to worksheet M-3, Title | * | 1, 541, 236 | 4 |
| | TO BE COMPLETED BY CONTRACTOR | | | | |
| 00 | List separately each tentative settlement payment after des | k review Also show date o | nf . | | 5 |
| 00 | each payment. If none, write "NONE" or enter a zero. (1) | in review. Also show date c | ´' | | |
| | Program to Provider | | | | |
| 01 | | | | 0 | 5 |
| 02 | | | | 0 | 5 |
| 03 | | | | 0 | 5 |
| | Provider to Program | | | | |
| 50 | | | | 0 | 5 |
| 51 | | | | 0 | 5 |
| 52 | | | | 0 | 5 |
| 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. | | | 0 | 5 |
| 00 | Determined net settlement amount (balance due) based on the | e cost report. (1) | | | 6 |
| 01 | SETTLEMENT TO PROVIDER | | | 325, 874 | 6 |
| 02 | SETTLEMENT TO PROGRAM | | | 0 | 6 |
| 00 | Total Medicare program liability (see instructions) | | Combined | 1, 867, 110 | 7 |
| | | | Contractor | NPR Date | |
| | | 0 | Number 1.00 | (Mo/Day/Yr) 2.00 | |
| | | U | 1 ()() | | |

| Health Financial Systems | HENRY COUNTY MEMORI | AL HOSPITAL | In Lieu | ı of Form CMS-2552-10 |
|--|---------------------|------------------------|-----------------------------|---------------------------------------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL | | Provider CCN: 15-0030 | Peri od: From 01/01/2021 | Worksheet M-5 |
| SERVI SES RENDERED TO TROOM IN DENET TOTAL | NI ES | Component CCN: 15-8556 | | Date/Time Prepared: 5/26/2022 3:43 pm |
| | | | RHC LLI | Cost |

| | | Component CCN: 15-8556 | To 12/31/2021 | 5/26/2022 3: 43 | |
|-------|---|-----------------------------|---------------|---------------------|-------|
| | | | RHC III | Cost | |
| | | | | rt B | |
| | | | mm/dd/yyyy | Amount | |
| | | | 1. 00 | 2. 00 | |
| 1.00 | Total interim payments paid to hospital-based RHC/FQHC | | | 81, 302 | 1.00 |
| 2.00 | Interim payments payable on individual bills, either submit | | | 0 | 2.00 |
| | the contractor for services rendered in the cost reporting | period. If none, write | | | |
| | "NONE" or enter a zero | | | | |
| 3.00 | List separately each retroactive lump sum adjustment amount | | | | 3.00 |
| | 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 | | | 12/01/2021 | 181, 600 | 3.0 |
| 3. 02 | | | | 0 | 3. 02 |
| 3. 03 | | | | 0 | 3.03 |
| 3.04 | | | | 0 | 3.04 |
| 3.05 | | | | 0 | 3. 0! |
| | Provider to Program | | | | |
| 3.50 | | | | 0 | 3.50 |
| 3. 51 | | | | 0 | 3. 5 |
| 3.52 | | | | 0 | 3.5 |
| 3.53 | | | | 0 | 3.5 |
| 3.54 | | | | 0 | 3.5 |
| 3. 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3. | 98) | | 181, 600 | 3.99 |
| 4.00 | Total interim payments (sum of lines 1, 2, and 3.99) (trans | sfer to Worksheet M-3, line | е | 262, 902 | 4.00 |
| | 27) | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | | | |
| 5.00 | List separately each tentative settlement payment after des | sk review. Also show date o | of | | 5.00 |
| | each payment. If none, write "NONE" or enter a zero. (1) | | | | |
| | Program to Provider | | | | |
| 5. 01 | | | | 0 | 5.0 |
| 5.02 | | | | 0 | 5.02 |
| 5.03 | | | | 0 | 5.03 |
| | Provider to Program | | | | |
| 5.50 | | | | 0 | 5. 50 |
| 5. 51 | | | | 0 | 5.5 |
| 5. 52 | | | | 0 | 5. 5. |
| 5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. | 98) | | 0 | 5. 9 |
| 6.00 | Determined net settlement amount (balance due) based on the | e cost report. (1) | | | 6.00 |
| 6. 01 | SETTLEMENT TO PROVIDER | • | | 33, 428 | 6.0 |
| 6.02 | SETTLEMENT TO PROGRAM | | | 0 | 6. 02 |
| 7. 00 | Total Medicare program liability (see instructions) | | | 296, 330 | 7.00 |
| 7.00 | | | Contractor | NPR Date | |
| 7.00 | | | | | |
| 7.00 | | | Number | (Mo/Day/Yr) | |
| 7.00 | | 0 | | (Mo/Day/Yr) 2.00 | |