Health Financi	al Systems	HENRY COUNTY MEMORJ	IAL HOSPITAL	In Lie	u of Form CMS-2552	-10
	s required by law (42 USC 1395g;					
payments made	since the beginning of the cost	reporting period being	deemed overpayments (42	USC 1395g).	OMB NO. 0938-0050 EXPIRES 05-31-201	
HOSPITAL AND H AND SETTLEMENT	HOSPITAL HEALTH CARE COMPLEX COST F SUMMARY	REPORT CERTIFICATION	Provider CCN: 15-0030	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepare 2/15/2017 2:12 pm	
PART I - COST	REPORT STATUS					
Provider	<ol> <li>[ X ] Electronically filed cos</li> </ol>	t report		Date: 2/15/20	17 Time: 2:12	pm
use only	2.[ ] Manually submitted cost	report				
	3.[0] If this is an amended re 4.[F] Medicare Utilization. En			esubmitted this co	ost report	
Contractor use only	5. [5] Cost Report Status 6. (1) As Submitted 7. (2) Settled without Audit 8. (3) Settled with Audit 9.	Contractor No. [ N ]Initial Report fo	11.0	IPR Date: Contractor's Vendo 0 ]If line 5, co number of tim	lumn 1 is 4: Enter	4 r

## PART II - CERTIFICATION

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

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HENRY COUNTY MEMORIAL HOSPITAL ( 15-0030 ) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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 jn this cost report were provided in compliance with such laws and regulations.

**Encryption Information** 

ECR: Date: 2/15/2017 Time: 2:12 pm XbOw.xiAUEHwI2cW4k1Y8DHaNt92k0 NIhaoONdLaYqrLi1e7jXFcvjozjgIk vIzn1TXQ2x0GW44L

(4) Reopened (5) Amended

Date: 2/15/2017 Time: 2:12 pm DwgMVY6Ib3E5h:haTheJ6L01dMT9Q0 lEzcZ0Q2lNdPMhuM5opRX:Un7eSqlX LM6g0EhYYf0cqJNE

(Signed)

officer or Administrator of Provider(s)
resident (CEO

2-16-2017

			Title >	(VIII				
		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	Hospital	0	1,561	15,117	37,904	-37,593	1.00	
2.00	Subprovider - IPF	0	0	0		0	2.00	
3.00	Subprovider - IRF	0	0	0		0	3.00	
4.00	SUBPROVIDER I						4.00	
5.00	Swing bed - SNF	0	0	0		0	5.00	
6.00	Swing bed - NF	0				0	6.00	
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00	
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00	
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00	
200.00	Total	0	1,561	15,117	37,904	-37,593	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0030 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 2/15/2017 2:11 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 Zi p Code: 47392-County: HENRY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 HENRY COUNTY MEMORIAL 150030 99915 07/01/1996 N 0 3.00 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA HCMH HOME CARE 157430 99915 06/14/1995 N Ρ Ν 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 HOSP-BASED HOSPICE 151564 99915 14.00 08/31/1998 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2015 12/31/2015 20.00 21.00 Type of Control (see instructions) 9 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Υ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Υ Υ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 | Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23 00 3 Ν 23 00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d Other In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2.00 3. 00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 204 678 830 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2. out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

Health Financial Systems	HENRY COUN	NTY MEM	ORIAL HOSPITAL		I	n Lie	u of Form	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CAR	RE COMPLEX IDENTIFICATION DA	TA	Provider CC	:N: 15-0030	Period: From 01/01		Workshe Part I		
					To 12/31.		2/15/20	17 2: 1	
					Urban/Ru 1.00		Date of 2.0		
	aphic classification (not wa ter "1" for urban or "2" for			jinning of th	ie	1			26. 00
27.00 Enter your standard geogra	aphic classification (not wa	ige) sta	atus at the end			1			27. 00
enter the effective date of	n column 1, "1" for urban or of the geographic reclassifi	cati on	in column 2.						
35.00 If this is a sole communication effect in the cost reportion		numbei	r of periods SC	CH status in		С	)		35. 00
					Begi nni 1. 00		Endi r 2. 0		
36.00 Enter applicable beginning	g and ending dates of SCH st ne and enter subsequent date		Subscript line	36 for number					36. 00
37.00 If this is a Medicare depe	endent hospital (MDH), enter		umber of period	ls MDH status	;	1			37. 00
	MDH that is eligible for th				N				37. 01
accordance with FY 2016 OF instructions)	PPS final rule? Enter "Y" fo	or yes o	or "N" for no.	(see					
	e beginning and ending dates this line for the number of				01/01/2	2015	12/31/	2015	38. 00
enter subsequent dates.				32	Y/N		Y/N	N	
20.00	. Fam that is a second as				1. 00		2. 0		20.25
hospitals in accordance wi	y for the inpatient hospital ith 42 CFR §412.101(b)(2)(ii	)? Ente	er in column 1	"Y" for yes	ne Y		Υ		39. 00
or "N" for no. Does the fa CFR 412.101(b)(2)(ii)? En	acility meet the mileage red ter in column 2 "Y" for yes	uiremen or "N"	nts in accordan for no. (see i	nce with 42 nstructions)					
40.00 Is this hospital subject	to the HAC program reduction or discharges prior to Octob	adj us	tment? Enter "Y	" for yes or	· N		N		40. 00
· · · · · · · · · · · · · · · · · · ·	arges on or after October 1.		,			l v	XVIII	XI X	
	(222)					1.00		3.00	
Prospective Payment System 45.00 Does this facility qualify	m (PPS)-Capital y and receive Capital paymer	it for (	di sproporti onat	e share in a	ccordance	N	N	N	45. 00
with 42 CFR Section §412.3 46.00 Is this facility eligible	320? (see instructions) for additional payment exce	eption 1	for extraordi na	ıry circumsta	inces	N	l N	N	46. 00
	48(f)? If yes, complete Wkst								
47.00 Is this a new hospital und 48.00 Is the facility electing	der 42 CFR §412.300 PPS capi full federal capital payment					N N	N N	N N	47. 00 48. 00
Teaching Hospitals  56.00 Is this a hospital involve	ed in training residents in	approve	ed GME programs	? Enter "Y"	for yes	N			56. 00
or "N" for no. 57.00 If line 56 is yes, is this	s the first cost reporting p	eriod (	during which re	esidents in a	pproved				57. 00
	his facility? Enter "Y" for t training in the first mont								
for yes or "N" for no in o	column 2. If column 2 is "Y	", com	olete Worksheet						
58.00 If line 56 is yes, did thi		urseme	nt for physicia	ıns' servi ces	as				58. 00
59.00 Are costs claimed on line		, compl	lete Wkst. D-2,			N			59. 00
60.00 Are you claiming nursing s	school and/or allied health a under §413.85? Enter "Y"					N			60.00
<u></u>		Y/N	IME	Direct GME			Di rect	GME	
(1.00   Di.d.	ETE -L-t- L AAA	1.00	2. 00	3. 00	4.00		5. 0		/4 25
61.00 Did your hospital receive section 5503? Enter "Y" for	or yes or "N" for no in	N				0.00	) 	0.00	61.00
column 1. (see instruction 61.01 Enter the average number of			0.00	0.	00				61. 01
	3 most recent cost reports								
i nstructi ons)	•		0.00		00				(1.02
61.02 Enter the current year to FTE count (excluding OB/G)	YN, general surgery FTEs,		0.00	0.	00				61. 02
and primary care FTEs addo ACA). (see instructions)	ed under section 5503 of								
61.03 Enter the base line FTE co	ount for primary care sidents, which is used for		0.00	0.	00				61. 03
determining compliance wi									
61.04 Enter the number of unweig			0.00	0.	00				61. 04
surgery allopathic and/or current cost reporting per	riod.(see instructions).								
61.05 Enter the difference betwee and/or general surgery FTI			0.00	0.	00				61. 05
	al surgery FTE counts (line								
101.04 minus fine 01.03).	(See Thisti detrons)	1	I I	ı	(		I		I

Health Financial Systems	HENRY COU	NTY MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CAN			Provi der CC		eriod: fom 01/01/2015 o 12/31/2015		pared:
		Y/N	I ME	Direct GME	I ME	Direct GME	рш
		1.00	2. 00	3. 00	4. 00	5. 00	
61.06 Enter the amount of ACA § used for cap relief and/o care or general surgery.	r FTEs that are nonprimary		0.00	0.00			61. 06
	,	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3. 00	4.00	
for each new program. (se column 1, the program nam program code, enter in co	e number of FTE residents e instructions) Enter in e, enter in column 2, the				0. 00	0.00	61. 10
61.20 Of the FTEs in line 61.05 program specialty, if any residents for each expand instructions) Enter in co enter in column 2, the pr	, and the number of FTE ed program. (see lumn 1, the program name, ogram code, enter in column count and enter in column				0. 00	0. 00	61. 20
						1. 00	
	the Health Resources and Se						
62.00 Enter the number of FTE r	esidents that your hospital SA PCRE funding (see instruc		lin this cost	reporting peri	od for which	0.00	62. 00
62.01 Enter the number of FTE r during in this cost repor	esidents that rotated from a ting period of HRSA THC pro	a Teachi gram. (s	see instruction		your hospital	0.00	62. 01
63.00 Has your facility trained	laim Residents in Nonprovider se residents in nonprovider se in column 1. If yes, comple	ettings	during this co		eriod? Enter	N	63. 00
THE YES OF IN TOTAL	THE COLUMN 1. THE YES, COMPTO	ete mie	23 04 07. (300	Unwei ghted	Unwei ghted	Ratio (col. 1/	
				FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
Section EEOA of the ACA B	ase Year FTE Residents in No	opprovid	dar Cattings 3	1. 00	2.00	3.00	
	after July 1, 2009 and befor			illis base year	rs your cost i	epor triig	
resident FTEs attributabl settings. Enter in colum resident FTEs that traine	e 63 is yes, or your facilithe number of unweighted nor e to rotations occurring in 2 the number of unweighted in your hospital. Enter in column 1 + column 2)). (see	n-primar all nor d non-pr n columr	ny care nprovider imary care n 3 the ratio	0. 00	0. 00	0. 000000	64. 00
	Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted 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 li is yes, or your facility trained residents in the year period, the program associated with primary car program in which you trai residents. Enter in column the program code, enter i column 3, the number of unweighted primary care Fresidents attributable to rotations occurring in al non-provider settings. En column 4, the number of unweighted primary care resident FTEs that traine your hospital. Enter in c 5, the ratio of (column 3 divided by (column 3 + co 4)). (see instructions)	base name are e ned n 2, n  TE I ter in d in olumn			0.00	0.00	0. 000000	65.00

Health Financial Systems HENRY COUNTY MEMO	ORIAL HOSPITAL		In Li	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		eriod: com 01/01/201! o 12/31/201!		epared:
		,	V	XI X	
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			1. 00 0. 00 N	2. 00 0. 00 N	95. 00 96. 00
applicable column.  97.00 If line 96 is "Y", enter the reduction percentage in the approximate approximately approximately approximately approximately approximately applicable column.	olicable column	٦.	0. 00	0.00	97. 00
105.00 Does this hospital qualify as a critical access hospital (C/L) 106.00 on this facility qualifies as a CAH, has it elected the all-		nod of payment	N N		105. 00 106. 00
for outpatient services? (see instructions)  107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see instr	ructions) If	N		107. 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.			N		108. 00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	$\perp$
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	109. 00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)for	N	110. 00
			1. (	00 2.00 3.00	
Miscellaneous Cost Reporting Information  115.00  Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider	. If column 2 int for long ter	s "E", enter i rm care (includ	n column les	0	115. 00
Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insur			N" for Y		116. 00 117. 00
118.00 s the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 i	f the policy i	s 1		118. 00
praisi made. Enter Enter periody to obtain the		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	_
118.01 List amounts of malpractice premiums and paid losses:		1			0118.01
			1. 00	2.00	_
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.	center other dule listing co	than the ost centers	N		118. 02
119. 00 D0 NOT USE THIS LINE 120. 00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies the second of	n column 1, "Y' ualifies for th	' for yes or ne Outpatient	N	N	119.00
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Y		121. 00
122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.			N		122. 00
Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for	or 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, en		fication date			126. 00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ening in column 1 and termination date, if applicable, in column 2	ter the certifi	cation date			127. 00
128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 2	ter the certifi	cation date			128. 00
129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		cation date in			129. 00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col	umn 2.				130. 00
131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified islet transplant center, en	umn 2.				131. 00 132. 00
in column 1 and termination date, if applicable, in column 2					

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFI	HENRY COUNTY MEM CATION DATA	Provi der CCI	l: 15-0030	Peri od:		u of Form CM Worksheet S Part I	
					2/31/2015	Date/Time P 2/15/2017 2	
					1. 00	2. 00	_
33.00 If this is a Medicare certified other trans in column 1 and termination date, if applic	·		cation date		1.00	2.00	133. 00
34.00 If this is an organ procurement organization and termination date, if applicable, in colu	n (OPO), enter tl		n column 1				134. 00
40.00 Are there any related organization or home chapter 10? Enter "Y" for yes or "N" for no are claimed, enter in column 2 the home off	in column 1. If	yes, and home	office cost	5	Υ		140. 00
1.00	2. 0	•	0113)		3. 00		
If this facility is part of a chain organiz home office and enter the home office contr				name and	d address	of the	
41. 00 Name: Cont	ractor's Name:			tor's Nu	mber:		141. 0
42.00 Street:   PO Bi 43.00 Ci ty:   Stati			Zi p Code	e:			142. 0 143. 0
p							
44.00 Are provider based physicians' costs include	ed in Worksheet	Δ?				1. 00 Y	144. 0
44. Ooki e provider based physicians costs include	od 111 worksheet 1	· · ·				1	144.0
45 001 6 1 6					1. 00	2. 00	1.45.0
45.00 If costs for renal services are claimed on inpatient services only? Enter "Y" for yes no, does the dialysis facility include Mediaperiod? Enter "Y" for yes or "N" for no in	or "N" for no in care utilization	column 1. If co	olumn 1 is		N		145. 00
46.00 Has the cost allocation methodology changed Enter "Y" for yes or "N" for no in column 1 yes, enter the approval date (mm/dd/yyyy) i	from the previous (See CMS Pub.			f	N		146. 0
						1.00	
47.00 Was there a change in the statistical basis						N	147. 0
48.00\mas there a change in the order of allocation 49.00\mas there a change to the simplified cost f				c no		N N	148. 0 149. 0
47. 00 was there a change to the shiph fired cost i	narng method: Ei	Part A	Part B		itle V	Title XIX	
D 11: 6 :1:1	1.6.	1.00	2.00		3. 00	4.00	
Does this facility contain a provider that or charges? Enter "Y" for yes or "N" for no							
55. 00 Hospi tal		N	N		N	N	155. 0
56.00 Subprovider - IPF 57.00 Subprovider - IRF		N N	N N		N N	N N	156. 0 157. 0
58. 00 SUBPROVI DER		14			IV.		158. 0
59. 00 SNF		N	N		N	N	159. C
60.00 HOME HEALTH AGENCY 61.00 CMHC		N	N N		N N	N N	160. C
01. 00 OMITO							101.0
Multicampus						1. 00	
65.00  s this hospital part of a Multicampus hosp Enter "Y" for yes or "N" for no.	tal that has one	e or more campu	ses in diffe	erent CB	SAs?	N	165. 0
N:	ame	County		p Code	CBSA	FTE/Campus	5
66.00 If line 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5. 00	00 166. 0
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						0.	00 100. 0
column 5 (see instructions)							
Health Information Tachnal (IIIT)	(0 in the A	an Doceston - 1	Doi nua-t-	n+ ^o+		1.00	
Health Information Technology (HIT) incenti 67.00 s this provider a meaningful user under §1: 68.00 f this provider is a CAH (line 105 is "Y")	386(n)? Enter "` and is a meaning	Y" for yes or " gful user (line	N" for no.		the	Y	167. C
reasonable cost incurred for the HIT assets 68.01 If this provider is a CAH and is not a mean exception under §413.70(a)(6)(ii)? Enter "Y	ngful user, does	s this provider			lshi p		168. C
							1

Health Financial Systems	HENRY COUNTY MEMO	RIAL HOSPITAL	In Lie	In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE COM	PLEX IDENTIFICATION DATA	Provider CCN: 15-0030	Peri od:	Worksheet S-2				
			From 01/01/2015					
			To 12/31/2015	Date/Time Pre				
				2/15/2017 2:1	1 pm			
			Begi nni ng	Endi ng				
			1. 00	2.00				
170.00 Enter in columns 1 and 2 the El	01/01/2015	12/31/2015	170. 00					
period respectively (mm/dd/yyyy	/)							
			1. 00	2.00				
171.00 If line 167 is "Y", does this p	provider have any days for ind	ividuals enrolled in	N	0	171. 00			
section 1876 Medicare cost plan	ns reported on Wkst. S-3, Pt.	I, line 2, col. 6? Enter						
"Y" for yes and "N" for no in o	column 1. If column 1 is yes,	enter the number of section	n					
1876 Medicare days in column 2.	(see instructions)							

	Financial Systems HENRY COUNTY MEMO AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0030	Period: From 01/01/2015 To 12/31/2015	u of Form CMS- Worksheet S-2 Part II Date/Time Pro 2/15/2017 2:	2 epared:
			· '	Y/N	Date	, , , , , , , , , , , , , , , , , , ,
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	sponses. Ente	r all dates in t	:he	
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co			N		1.00
	reporting period: 11 yes, enter the date of the change in co	orumir 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2. 00
3. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)			3.00		
			Y/N	Type	Date	
	Financial Data and Danarta		1.00	2. 00	3. 00	
4. 00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled, lable in	Y	A		4.00
5.00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco		IN IN			5. 00
	those on the fired financial statements. If yes, submit rece	SHOTT GET OIL		Y/N	Legal Oper.	
				1. 00	2.00	
6. 00	Approved Educational Activities  Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider is	N N		6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		I during the	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved (		al education	N		9. 00
10. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		he current	N		10. 00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00
					Y/N 1. 00	
	Bad Debts				1.00	
12. 00	Is the provider seeking reimbursement for bad debts? If yes,	see instruct	i ons.		Υ	12. 00
	If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.	, ,	Ü		N	13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement	ııs warved? IT	yes, see ins	ELL UCTIONS.	N	14. 00
15. 00	Did total beds available change from the prior cost reporting	<del></del>	yes, see inst t A	ructions. Par	Y t B	15. 00
		Y/N	Date	Y/N	Date	
	DS&D Data	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	04/06/2016	Y	04/06/2016	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 MEM	MORIAL HOSPITAL	_	In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0030	Peri od: From 01/01/2015 To 12/31/2015	Worksheet S Part II Date/Time P 2/15/2017 2	repared:
		Descr	i pti on	Y/N	Y/N	
			0	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		_	N	N	20. 00
		Y/N	Date	Y/N	Date	
	I	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 (EXCE	EPT CHILDRENS H	HOSPI TALS)		1.00	
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sals made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	N	24. 00			
25. 00	Have there been new capitalized leases entered into during instructions.	If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	f yes, see	N	26. 00		
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit er	Υ	28. 00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instructions.	N	29. 00			
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.	Υ	30. 00			
31. 00	Has debt been recalled before scheduled maturity without is instructions.	, see	N	31. 00		
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care ser		ed through co	ntractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an ar	rangement with	n provi der-ba	sed physi ci ans?	N	34. 00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	sting agreemer	nts with the	provi der-based	N	35. 00
	physicians during the cost reporting period? If yes, see in	nstructi ons.		V (1)	5 .	
				Y/N 1. 00	2. 00	
	Home Office Costs			1.00	2.00	
36. 00	Were home office costs claimed on the cost report?			N		36.00
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			37. 00
	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off					38. 00
	the provider? If yes, enter in column 2 the fiscal year end	d of the home o	offi ce.			
39. 00	see instructions.	•	,			39.00
40. 00	If line 36 is yes, did the provider render services to the instructions.	N		40. 00		
		1	. 00	2.	00	
	Cost Report Preparer Contact Information	1.		Ζ.	00	
41. 00		KYLE	SMI TH		41. 00	
42. 00	respecti vel y.	BLUE & CO., LL	_C			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost	317-713-7957		KCSMI TH@BLUEANI	OCO COM	43.00
<del>4</del> 3.00	report preparer in columns 1 and 2, respectively.	017 713-7737		NOSWI THEDEULANI	555. GOW	43.00

Heal th	Financial Systems HENRY COUNTY	MEMO	RIAL HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPI 7	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15	Peri od:	Worksheet S-2	
				From 01/01/2015 To 12/31/2015		
		L				
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	SI	ENI OR MANAGER			41. 00
	held by the cost report preparer in columns 1, 2, and 3,					
	respecti vel y.					
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.					
42. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost				2/15/2017 2: 1	41.00

Health Financial Systems HENRY COUNTY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2015 | Part I | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 15-0030

						10 12/31/2015	2/15/2017 2:1		
							I/P Days / 0/P	. p	
							Visits / Trips		
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V		-
	55p5.115112	Line Number		o. Dogo	Avai I abl e	0,11, 11041.0			
		1. 00		2. 00	3.00	4. 00	5. 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		38			0	1. 00	<u>_</u>
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)							2.00	0
3.00	HMO IPF Subprovider							3.00	0
4.00	HMO IRF Subprovider							4. 00	
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00	
6. 00	Hospital Adults & Peds. Swing Bed NF						0	6. 00	
7. 00	Total Adults and Peds. (exclude observation			38	13, 87	0.00		7. 00	
7.00	beds) (see instructions)			00	10,07	0.00		,	,
8. 00	INTENSIVE CARE UNIT	31. 00		10	3, 65	0.00	0	8.00	O
9. 00	CORONARY CARE UNIT	011.00			0,00	0.00		9. 00	
10. 00	BURN INTENSIVE CARE UNIT							10.00	
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00	
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00	
13. 00	NURSERY	43. 00					0	13.00	
14. 00	Total (see instructions)	43.00		48	17, 52	0.00		14.00	
15. 00	CAH visits			40	17, 32	0.00	0	15. 00	
16. 00	SUBPROVI DER - I PF							16. 00	
17. 00	SUBPROVI DER - I RF	41. 00		0		0	0	17. 00	
18. 00	SUBPROVI DER	42. 00		0		0	0	18. 00	
19. 00	SKILLED NURSING FACILITY	42.00		O		o e		19.00	
20. 00	NURSING FACILITY							20.00	
21. 00	OTHER LONG TERM CARE							21.00	
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00	
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	101.00						23. 00	
24. 00	HOSPI CE	116, 00		0		0		24.00	
24. 10	HOSPICE (non-distinct part)	30.00		O		o e		24. 10	
25. 00	CMHC - CMHC	30.00						25. 00	
26. 00	RURAL HEALTH CLINIC	88. 00					0	26.00	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25	
27. 00		89.00		48				27. 00	
28. 00	Observation Bed Days			40			0	28.00	
29. 00							0	29.00	
30.00	Ambulance Trips Employee discount days (see instruction)							30.00	
31. 00								31.00	
				0					
32. 00	Labor & delivery days (see instructions)			Ü		0		32.00	
32. 01	Total ancillary labor & delivery room							32. 01	1
22 00	outpatient days (see instructions)							33.00	Λ
33.00	LTCH non-covered days		l		I		I	33.00	J

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CC Provider CCN: 15-0030

						2/15/2017 2:1	1 pm
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		191	5, 407			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)	840	1, 287				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	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	0.005	0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	2, 905	191	5, 407			7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	988	0	1, 742			8. 00
9.00	CORONARY CARE UNIT	900	U	1, 742			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	812			13.00
14. 00	Total (see instructions)	3, 893	191	7, 961	0.00	439. 43	
15. 00	CAH visits	0,070	0			107.10	15. 00
16. 00	SUBPROVIDER - I PF		J	Ĭ			16. 00
17. 00	SUBPROVIDER - I RF	0	0	0	0.00	0.00	•
18. 00	SUBPROVI DER		0	Ö	0.00		1
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	5, 450	54	8, 645	0.00	12. 38	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	5, 719	120	6, 217	0.00	5. 59	24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0	0	0	0.00	l .	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00		
27. 00	Total (sum of lines 14-26)				0.00	457. 40	1
28. 00	,		41	1, 664			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30. 00				0			30.00
31. 00				0			31.00
32.00	,	0	234	350			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
22 00	outpatient days (see instructions)	0					33. 00
33.00	LTCH non-covered days	ı Y		I	I	I	J 33. 00

| Period: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Health Financial Systems HENRY COUNTY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0030

					To 12/31/2015	Date/Time Pre 2/15/2017 2:1	
		Full Time Equivalents	<u> </u>	Dis	charges		•
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		,	0 1, 0	40 38	2, 174	1. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)			21	01 343 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY	0.00			40	0.474	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00	Total (see instructions) CAH visits	0. 00		0 1, 0	40 38	2, 174	15. 00
16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 23. 00 24. 00 24. 10 25. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	Employee discount days (see instruction)	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00		0	0 0	0	16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00
	outpatient days (see instructions) LTCH non-covered days						33. 00

| Period: | Worksheet S-3 | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0030

					To	12/31/2015		
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	ı pili
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Worksheet A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
		1.00	2.00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1. 00	Total salaries (see	200. 00	31, 189, 220	0	31, 189, 220	1, 106, 010. 00	28. 20	1. 00
	instructions)							
2. 00	Non-physician anesthetist Part		C	0	0	0. 00	0. 00	2. 00
3.00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	3. 00
4. 00	B Physician-Part A -		C	0	0	0.00	0. 00	4. 00
4.00	Administrative		C	,		0.00	0.00	4.00
4. 01	Physicians - Part A - Teaching		C	_	0	0.00		4. 01
5. 00	Physician and Non Physician-Part B		C	0	0	0. 00	0. 00	5. 00
6.00	Non-physician-Part B for		C	0	0	0.00	0. 00	6. 00
	hospital-based RHC and FQHC services							
7.00	Interns & residents (in an	21. 00	C	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and				0	0.00	0. 00	7. 01
7.01	residents (in an approved		C	,		0.00	0.00	7.01
0.00	programs)					0.00	0.00	0.00
8. 00	Home office and/or related organization personnel		C	0	U	0. 00	0.00	8. 00
9.00	SNF	44. 00		0	0	0.00		
10. 00	Excluded area salaries (see instructions)		6, 410, 387	459, 414	6, 869, 801	214, 524. 00	32. 02	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient Care		838, 560	0	838, 560	20, 994. 00	39. 94	11. 00
12. 00	Contract Labor: Top Level		C	0	0	0.00	0. 00	12. 00
	management and other management and administrative							
	servi ces							
13. 00	Contract Labor: Physician-Part A - Administrative		177, 004	0	177, 004	1, 532. 00	115. 54	13. 00
14. 00	Home office and/or related		C	o	0	0.00	0.00	14. 00
	orgainzation salaries and wage-related costs							
14. 01	Home office salaries		C	0	0	0.00	0. 00	14. 01
14. 02	Related organization salaries		C	0	0	0.00		
15. 00	Home office: Physician Part A - Administrative		C	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract		C	0	0	0.00	0. 00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		8, 190, 357	0	8, 190, 357			17. 00
18. 00	instructions) Wage-related costs (other)		C	0	0			18. 00
	(see instructions)							
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 351, 993	0	1, 351, 993			19. 00 20. 00
20.00	A		C					20.00
21. 00	Non-physician anesthetist Part		C	0	0			21. 00
22. 00	Physician Part A -		C	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		C	_	0			22. 01
23. 00	Physician Part B		C	Ö	0			23. 00
24. 00	Wage-related costs (RHC/FQHC)		C	0	0			24.00
25. 00	Interns & residents (in an approved program)		C	0	0			25. 00
25. 50	Home office wage-related							25. 50
25. 51	Related orgainzation wage-related							25. 51
25. 52	Home office: Physician Part A							25. 52
	- Administrative - wage-related							
25. 53	Home office & Contract							25. 53
	Physicians Part A - Teaching - wage-related							
	OVERHEAD COSTS - DIRECT SALARIE			1				
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	950, 022 5, 560, 805			8, 119. 00 175, 912. 00		26. 00 27. 00
27.00	I Strative a beliefal	5.00	3, 300, 603	130,003	J, 077, 000	173, 712.00	JZ. 39	27.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0030

31. 00 Laundry & Linen Service								2/15/2017 2: 1	1 pm
1.00   2.00   3.00   4.00   5.00   6.00			Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
28. 00   Administrative & General under contract (see inst.)   1.00   2.00   3.00   4.00   5.00   6.00   6.00   6.00   725, 484   0   725, 484   6,100.00   118.93   28.			Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
1.00   2.00   3.00   4.00   5.00   6.00					(from	(col.2 ± col.	Salaries in	col . 5)	
28. 00   Administrative & General under contract (see inst.)   725, 484   0   725, 484   0   725, 484   6, 100. 00   118. 93   28.     29. 00   Maintenance & Repairs   6. 00   0   0   0   0   0   0   0   0   0					Worksheet A-6)				
29.00 Maintenance & Repairs 6.00 0 0 0 0 0.00 29. 30.00 Operation of Plant 7.00 986,040 22,519 1,008,559 42,106.00 23.95 30. 31.00 Laundry & Linen Service 8.00 0 0 0 0.00 0.00 31. 32.00 Housekeeping 9,00 465,052 -31,640 433,412 39,033.00 11.10 32. 33.00 Housekeeping under contract (see instructions) 10.00 685,168 -462,176 222,992 14,095.00 15.82 34. 35.00 Di etary under contract (see instructions) 11.00 0 278,726 278,726 18,342.00 15.20 36. 36.00 Cafeteria 11.00 0 278,726 278,726 18,342.00 15.20 36. 37.00 Maintenance of Personnel 12.00 0 0 0.00 0.00 37. 38.00 Nursing Administration 13.00 1,559,009 41,786 1,600,795 38,419.00 41.67 38. 39.00 Central Services and Supply 14.00 417,028 11,387 428,415 16,169.00 26.50 39. 40.00 Pharmacy 15.00 0 0 0 0.00 0.00 40. 41.00 Medical Records & Medical Records Library 17.00 0 0 0 0 0.00 0.00 42.			1.00						
29. 00       Maintenance & Repairs       6. 00       0       0       0       0.00       0.00       0.00       29.         30. 00       Operation of Plant       7. 00       986,040       22,519       1,008,559       42,106.00       23.95       30.         31. 00       Laundry & Linen Service       8. 00       0       0       0       0.00       0.00       0.00       31.         32. 00       Housekeeping under contract (see instructions)       9. 00       465,052       -31,640       433,412       39,033.00       11. 10       32.         34. 00       Di etary       10. 00       685,168       -462,176       222,992       14,095.00       15. 82       34.         35. 00       Di etary under contract (see instructions)       0       0       0       0.00       0.00       0.00       35.         36. 00       Cafeteria       11. 00       0       278,726       278,726       18,342.00       15. 20       36.         37. 00       Maintenance of Personnel       12. 00       0       0       0       0       0.00       0.00       37.         38. 00       Nursing Administration       13. 00       1,559,009       41,786       1,600,795       38,419.00 <td>28.00</td> <td>Administrative &amp; General under</td> <td></td> <td>725, 484</td> <td>0</td> <td>725, 484</td> <td>6, 100. 00</td> <td>118. 93</td> <td>28. 00</td>	28.00	Administrative & General under		725, 484	0	725, 484	6, 100. 00	118. 93	28. 00
30. 00   Operation of Plant									1
31. 00 Laundry & Linen Service	29. 00		6. 00	0	0	0			
32. 00 Housekeeping	30.00	Operation of Plant	7. 00	986, 040	22, 519	1, 008, 559	42, 106. 00	23. 95	30.00
33.00 Housekeeping under contract (see instructions)  34.00 Di etary	31.00	Laundry & Linen Service	8. 00	0	0	0	0.00	0.00	31. 00
(see instructions) 34.00 Di etary 35.00 Di etary under contract (see instructions) 36.00 Cafeteria 37.00 Maintenance of Personnel 38.00 Nursi ng Administration 39.00 Central Services and Supply 40.00 Pharmacy 42.00 Soci al Service  10.00 685, 168 -462, 176 222, 992 14, 095. 00 15. 82 34.  0 0 0 0 0 0 0.00 35.  11.00 0 0 278, 726 278, 726 18, 342. 00 15. 20 36.  0 0 0 0 0 0 0.00 0.00 37.  12.00 0 0 0 0 0.00 0.00 37.  13.00 1, 559, 009 41, 786 1, 600, 795 38, 419. 00 41. 67 38.  14.00 417, 028 11, 387 428, 415 16, 169. 00 26. 50 39.  15.00 0 0 0 0 0 0.00 0.00 40.  15.00 594, 488 11, 979 606, 467 28, 420. 00 21. 34 41.  16.00 594, 488 11, 979 606, 467 28, 420. 00 21. 34 41.	32.00	Housekeepi ng	9. 00	465, 052	-31, 640	433, 412	39, 033. 00	11. 10	32. 00
34. 00 Di etary under contract (see instructions)  36. 00 Cafeteria 11. 00 0 278, 726 278, 726 18, 342. 00 15. 20 36. 37. 00 Mai ntenance of Personnel 12. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 37. 38. 00 Nursi ng Administrati on 13. 00 1, 559, 009 41, 786 1, 600, 795 38, 419. 00 41. 67 38. 39. 00 Central Services and Supply 14. 00 417, 028 11, 387 428, 415 16, 169. 00 26. 50 39. 41. 00 Medi cal Records & Medi cal Records & Medi cal Records & Medi cal Service 17. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00	Housekeeping under contract		0	0	0	0.00	0.00	33. 00
35. 00 Di etary under contract (see instructions) 36. 00 Cafeteria 11. 00 0 278, 726 278, 726 18, 342. 00 15. 20 36. 37. 00 Mai ntenance of Personnel 12. 00 0 0 0 0 0 0. 00 37. 38. 00 Nursi ng Admi ni strati on 13. 00 1, 559, 009 41, 786 1, 600, 795 38, 419. 00 41. 67 38. 39. 00 Central Services and Supply 14. 00 417, 028 11, 387 428, 415 16, 169. 00 26. 50 39. 40. 00 Medi cal Records & Medi cal 16. 00 594, 488 11, 979 606, 467 28, 420. 00 21. 34 41. Records Li brary 42. 00 Soci al Service 17. 00 0 0 0 0 0 0. 00 0. 00 42.		(see instructions)							1
instructions) 36. 00 Cafeteria	34.00	Di etary	10. 00	685, 168	-462, 176	222, 992	14, 095. 00	15. 82	34.00
36. 00 Cafeteria 11. 00 0 278, 726 278, 726 18, 342. 00 15. 20 36. 37. 00 Maintenance of Personnel 12. 00 0 0 0 0 0. 00 37. 38. 00 Nursing Administration 13. 00 1, 559, 009 41, 786 1, 600, 795 38, 419. 00 41. 67 38. 39. 00 Central Services and Supply 14. 00 417, 028 11, 387 428, 415 16, 169. 00 26. 50 39. 40. 00 Pharmacy 15. 00 0 0 0 0 0. 00 0. 00 40. 41. 00 Medical Records & Medical Records Library 42. 00 Social Service 17. 00 0 0 0 0 0 0. 00 42.	35.00	Di etary under contract (see		0	0	0	0.00	0.00	35. 00
37. 00     Mai ntenance of Personnel     12. 00     0     0     0     0. 00     0. 00     37.       38. 00     Nursi ng Admi ni strati on     13. 00     1,559,009     41,786     1,600,795     38,419.00     41.67     38.       39. 00     Central Servi ces and Supply     14. 00     417,028     11,387     428,415     16,169.00     26.50     39.       40. 00     Pharmacy     15. 00     0     0     0     0.00     0.00     0.00     40.       41. 00     Medi cal Records & Medi cal Records Li brary     16. 00     594,488     11,979     606,467     28,420.00     21. 34     41.       42. 00     Soci al Servi ce     17. 00     0     0     0     0.00     0.00     0.00     42.		instructions)							l
38. 00     Nursi ng Admi ni strati on Central Servi ces and Suppl y     13. 00     1,559,009     41,786     1,600,795     38,419.00     41.67     38.       39. 00     Central Servi ces and Suppl y     14. 00     417,028     11,387     428,415     16,169.00     26.50     39.       40. 00     Pharmacy     15. 00     0     0     0     0.00     0.00     0.00     40.       41. 00     Medi cal Records & Medi cal Records Li brary     16. 00     594,488     11,979     606,467     28,420.00     21. 34     41.       42. 00     Soci al Servi ce     17. 00     0     0     0     0.00     0.00     0.00     42.	36.00	Cafeteri a	11. 00	0	278, 726	278, 726	18, 342. 00	15. 20	36. 00
39.00   Central Services and Supply   14.00   417,028   11,387   428,415   16,169.00   26.50   39.	37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
40. 00 Pharmacy       15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	38. 00	Nursing Administration	13. 00	1, 559, 009	41, 786	1, 600, 795	38, 419. 00	41. 67	38. 00
41. 00     Medi cal Records & Medi cal Records & Medi cal Records Li brary     16. 00     594, 488     11, 979     606, 467     28, 420. 00     21. 34     41.       42. 00     Soci al Servi ce     17. 00     0     0     0     0.00     0.00     42.	39. 00	Central Services and Supply	14. 00	417, 028	11, 387	428, 415	16, 169. 00	26. 50	39. 00
Records Li brary 42. 00   Soci al Servi ce   17. 00   0   0   0. 00   0. 00   42.	40.00	Pharmacy	15. 00	0	0	0	0.00	0.00	40. 00
42. 00   Social Service   17. 00   0   0   0. 00   0. 00   42.	41.00	Medical Records & Medical	16. 00	594, 488	11, 979	606, 467	28, 420. 00	21. 34	41.00
		Records Library							1
43.00 Other General Service 1 18.00 0 0 0 0 0 0 0 0 43	42.00	Social Service	17. 00	0	0	0	0.00	0.00	42. 00
43. 00   0 ther deficial service   10. 00   0   0   0   0   0   0   0   0	43.00	Other General Service	18. 00	0	0	0	0.00	0. 00	43.00

instructions)

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0030 Worksheet S-3 Peri od: From 01/01/2015 To 12/31/2015 Part III Date/Time Prepared: 2/15/2017 2:11 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 31, 914, 704 31, 914, 704 1, 112, 110. 00 28. 70 1.00 instructions) 2.00 6, 410, 387 459, 414 6, 869, 801 214, 524. 00 32. 02 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 25, 504, 317 -459, 414 25, 044, 903 897, 586. 00 27.90 3.00 minus line 2) 4.00 Subtotal other wages & related 1, 015, 564 1, 015, 564 22, 526. 00 45.08 4.00 costs (see inst.) Subtotal wage-related costs 5.00 8, 190, 357 Ω 8, 190, 357 0.00 32. 70 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 34, 710, 238 -459, 414 34, 250, 824 920, 112. 00 37 22 7.00 Total overhead cost (see 11, 943, 096 -696, 442 11, 246, 654 386, 715. 00 29. 08 7.00

	10 12/31/2015	2/15/2017 2:1	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	995, 980	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		l
5.00	401K/TSA Plan Administration fees	787	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		l
8.00	Health Insurance (Purchased or Self Funded)	4, 614, 022	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)		8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8. 02
8.03	Health Insurance (Purchased)		8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	129, 766	
11. 00	Life Insurance (If employee is owner or beneficiary)	160, 907	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)	223, 829	
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	159, 059	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		l
	TAXES		
	FICA-Employers Portion Only	1, 774, 974	
	Medicare Taxes - Employers Portion Only	0	
19. 00	Unemployment Insurance	18, 357	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
22.00	instructions))		22.00
22. 00	Day Care Cost and Allowances	0	
	Tuition Reimbursement	0 077 (01	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	8, 077, 681	24. 00
25 00	Part B - Other than Core Related Cost	4E1 710	25.00
25.00	OTHER	451, 713	∠5. 00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0030		Worksheet S-3
		From 01/01/2015	
		T- 10/01/001F	D-+- /T! D

		1	0 12/31/2015	Date/lime Prep   2/15/2017 2:1	
	Cost Center Description		Contract Labor		ı pili
	odst dontor boson per on		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0	1. 00
2.00	Hospi tal		0	0	2. 00
3.00	Subprovi der - I PF				3. 00
4.00	Subprovi der - I RF		0	0	4.00
5.00	Subprovi der - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	Hospi tal -Based SNF				8. 00
9. 00	Hospi tal -Based NF				9. 00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	11. 00
12.00	Separately Certified ASC				12.00
13.00	Hospi tal -Based Hospi ce		0	0	13.00
14.00	Hospital-Based Health Clinic RHC		0	0	14.00
15. 00	Hospital-Based Health Clinic FQHC		0	0	15. 00
16.00	Hospi tal -Based-CMHC				16. 00
17. 00	Renal Dialysis				17. 00
18. 00	Other		0	0	18. 00

	<u> </u>	ENRY COUNTY MEN				eu of Form CMS-2	
HOME H	EALTH AGENCY STATISTICAL DATA			CN: 15-0030	Peri od: From 01/01/2015		
			Component	CCN: 15-7430	To 12/31/2015	2/15/2017 2:1	pared: 1 pm
					Home Health Agency I	PPS	
					1.	00	
0.00	County				0.11		0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA						1 00
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00	_	1	0 0. 00		
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
			)	1.00	2. 00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		0.00	0. ( 0. (		•	
5. 00	Other Administrative Personnel			0.0		•	1
6.00	Di rect Nursi ng Servi ce			0.0		•	
7. 00 8. 00	Nursi ng Supervi sor Physi cal Therapy Servi ce			0.0		•	
9. 00	Physi cal Therapy Supervisor			0. 0	0.00	0.00	
10.00	Occupational Therapy Service			0.0		•	
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0.0			
13. 00	Speech Pathology Supervisor			0. (		•	13. 00
14.00	Medical Social Service			0.0			14.00
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0. (		1	15. 00 16. 00
17. 00	Home Health Aide Supervisor			0. 0	0.00	0.00	1
18. 00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0. (	0.00	0.00	18. 00
19. 00	Enter in column 1 the number of CBSAs where				3		19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			34620			20.00
	during this cost reporting period (line 20 contains the first code).						
20. 01	contains the first code).			50031			20. 01
20. 02		Full Fr	 oi sodes	99915			20. 02
		Wi thout	With Outliers	LUPA Epi sode	,	Total (col s.	
		0utliers 1.00	2.00	3.00	Epi sodes 4. 00	1-4) 5. 00	
21 00	PPS ACTIVITY DATA						21 00
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	2, 149 569, 229		1	50 33 00 8, 778	•	1
23. 00	Physical Therapy Visits	1, 861	39	9	12 22	1, 934	23. 00
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	493, 999 509			92 5, 852 0 28	•	1
26. 00	Occupational Therapy Visits Charges	131, 714		1	0 7, 280		1
27. 00	Speech Pathology Visits	40	C		0 1	41	27. 00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	10, 264		1	0 260	1	1
30.00	Medical Social Service Visit Charges	0	l e e e e e e e e e e e e e e e e e e e	1	0 0	1	1
31.00	Home Health Aide Visits	454		1	0 12	1	1
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	56, 432 5, 013			0 1, 500 52 96	•	
	29, and 31)						
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	1, 261, 638	-	16, 49	0 92 23, 670	0 1, 368, 397	
	30, 32, and 34)						
36. 00	Total Number of Episodes (standard/non outlier)	312		-	20 4		
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	117	18	3	0 0		37. 00 38. 00
	,		,	•	,		

Heal th	Financial Systems	HE	NRY COUNTY MEM	ORIAL HOSPITAL		In lie	eu of Form CMS-2	2552-10
	TAL-BASED HOSPICE IDENTIFICATION		NACT COOKET WEN	Provi der CO		Period: From 01/01/2015 To 12/31/2015	Worksheet S-9 PARTS I THROU	GH IV
				oop. oo oo.			2/15/2017 2:1	
						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursi ng Facility	Facility		5)	
		1. 00	2.00	3.00	4, 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO					0.00	0.00	
1.00	Hospice Continuous Home Care	0	0	0	· · · · · · · · · · · · · · · · · · ·	0 0	0	1.00
2.00	Hospice Routine Home Care	5, 673	115	3, 100		0 376	6, 164	2. 00
3.00	Hospice Inpatient Respite Care	5	0	0		0	5	3. 00
4.00	Hospice General Inpatient Care	41	5	0		0 2	48	4. 00
5.00	Total Hospice Days	5, 719		3, 100		0 378	6, 217	5. 00
	Part II - CENSUS DATA FOR COST					_		
6. 00	Number of patients receiving hospice care	107	3	62		0 5	115	6. 00
7.00	Total number of unduplicated	0. 00		0.00				7. 00
	Continuous Care hours billable							
	to Medicare							
8. 00	Average Length of Stay (line 5 / line 6)	53. 45	40. 00	50. 00	0.0	0 75.60	54. 06	
9. 00	Unduplicated census count	89	2	53		0 5	96	9. 00
NOTE:	Parts I and II, columns 1 and 2	also include 1	the days report					
				Title XVIII	Title XIX	0ther	Total (sum of	
							col s. 1	
				1.00	2.00	2.00	through 3)	
	PART III - ENROLLMENT DAYS FOR	COST DEDODTING	DEDLODS DECLA	1.00	2.00	3. 00	4. 00	
10. 00	Hospice Continuous Home Care	COST REPORTING	PERIODS DEGIN	INTING ON OR AFT	ER UCTUBER I,	2013		10. 00
11. 00	Hospice Routine Home Care							11.00
12.00	Hospice Inpatient Respite Care							12.00
13. 00	Hospice General Inpatient Care							13.00
14. 00	1 .							14. 00
<del>-</del>	PART IV - CONTRACTED STATISTICA	AL DATA FOR COS	T REPORTING PE	RIODS BEGINNIN	G ON OR AFTER	OCTOBER 1, 201	5	
15.00	Hospice Inpatient Respite Care							15. 00
16.00	Hospice General Inpatient Care							16. 00

Heal th	Financial Systems HENRY COUNTY MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CO	CN: 15-0030	Peri od:	Worksheet S-1	0
				From 01/01/2015 To 12/31/2015	Date/Time Pre 2/15/2017 2:1	
					1. 00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by li	ne 202 colum	า 8)	0. 310307	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				4, 503, 186	
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3. 00
4.00	If line 3 is "yes", does line 2 include all DSH or supplement	1 2	from Medicai	d?	N	4. 00
5.00	If line 4 is "no", then enter DSH or supplemental payments fr	om Medicaid			2, 073, 722	•
6. 00	Medi cai d charges				14, 907, 597	
7.00	Medicaid cost (line 1 times line 6)		6.11		4, 625, 932	1
8. 00	Difference between net revenue and costs for Medicaid program	(line / min	us sum of II	nes 2 and 5; if	0	8. 00
	<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions</pre>	for each lin	٥)			
9. 00	Net revenue from stand-alone CHIP	TOT Each Till	e)		0	9. 00
10. 00	Stand-alone CHIP charges				0	
11. 00	Stand-alone CHIP cost (line 1 times line 10)				Ö	
12. 00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9:	f < zero then	0	
.2.00	enter zero)	(11110 11 1111	,,	20.0		12.00
	Other state or local government indigent care program (see in	structions f	or each line	)		
13.00	Net revenue from state or local indigent care program (Not in	cluded on li	nes 2, 5 or	9)	0	13. 00
14.00	Charges for patients covered under state or local indigent ca	re program (	Not included	in lines 6 or	0	14. 00
	10)					
15. 00	State or local indigent care program cost (line 1 times line	,			0	
16. 00	Difference between net revenue and costs for state or local i	ndigent care	program (li	ne 15 minus line	0	16. 00
	13; if < zero then enter zero)					
17. 00	Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to	funding char	ity caro		0	17. 00
18. 00	Government grants, appropriations or transfers for support of				0	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and loc			e (sum of lines	0	1
17.00	8, 12 and 16)	ai indigent	care program	s (suii oi iiiles	U	19.00
	10/ 12 414 10/		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1.00	2. 00	3. 00	
20.00	Charity care charges for the entire facility (see instruction	,	1, 949, 1		1, 949, 121	•
21. 00	Cost of patients approved for charity care (line 1 times line	20)	604, 8		604, 826	
22. 00	Partial payment by patients approved for charity care			0 0	0	
23. 00	Cost of charity care (line 21 minus line 22)		604, 8	26 0	604, 826	23. 00
					1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patie	nt days hevo	nd a Length	of stay limit	1.00 N	24. 00
24.00	imposed on patients covered by Medicaid or other indigent car		nd a rength	or stay rimit	IN .	24.00
25. 00	If line 24 is "yes," charges for patient days beyond an indi		ogram's Leng	th of stav limit	0	25. 00
26. 00	Total bad debt expense for the entire hospital complex (see i				3, 531, 504	
27. 00		,			233, 558	•
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (		s line 27)		3, 297, 946	•
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt e		,	e 28)	1, 023, 376	•
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 628, 202	30. 00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			1, 628, 202	31.00

Health Financial Systems	ENRY COUNTY MEMOI	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		eri od:	Worksheet A	
				rom 01/01/2015 o 12/31/2015	Date/Time Pre	narod:
			'	0 12/31/2013	2/15/2017 2: 1	pared. 1 pm
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Tri al Bal ance	
					(col. 3 +-	
	1.00	2. 00	3.00	4. 00	col . 4) 5. 00	
GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1.00 OO100 NEW CAP REL COSTS-BLDG & FIXT		4, 811, 672	4, 811, 672	-34, 728	4, 776, 944	1. 00
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP		0	) c	743, 180	743, 180	2. 00
3.00   00300 OTHER CAPITAL RELATED COSTS		0	) C	0	0	3. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	950, 022	7, 247, 240			7, 609, 886	4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	5, 560, 805	8, 455, 191	1		14, 152, 849	5. 00
7.00   00700   0PERATION OF PLANT 8.00   00800   LAUNDRY & LINEN SERVICE	986, 040	1, 669, 145 313, 933			2, 677, 659 313, 933	7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG	465, 052	272, 460	1	1	683, 683	9. 00
10. 00   01000   DI ETARY	685, 168	539, 823	1		389, 208	10.00
11. 00   01100   CAFETERI A	0	0	1	1	498, 326	11. 00
13.00 01300 NURSING ADMINISTRATION	1, 559, 009	305, 802	1, 864, 811	41, 786	1, 906, 597	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	417, 028	389, 073			817, 488	14. 00
15. 00   01500   PHARMACY	0	3, 743, 198			3, 604, 377	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	594, 488	252, 698	847, 186	11, 979	859, 165	16. 00
30. 00 03000 ADULTS & PEDIATRICS	3, 143, 794	396, 260	3, 540, 054	-617, 525	2, 922, 529	30. 00
31. 00   03100   NTENSI VE CARE UNI T	1, 128, 217	109, 353			1, 254, 865	31. 00
41. 00   04100   SUBPROVI DER -   RF	0	0		0	0	41.00
42. 00   04200   SUBPROVI DER	o	0	c	o	0	42. 00
43. 00   04300   NURSERY	0	0	C	568, 462	568, 462	43. 00
ANCI LLARY SERVI CE COST CENTERS  50, 00 05000 OPERATI NG ROOM	1 015 027	1 047 4/5	2, 962, 501	250 552	2, 703, 948	F0 00
50.00   05000   OPERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 915, 036	1, 047, 465	2, 962, 501		102, 205	50. 00 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 436, 809	759, 577	1		1, 946, 841	54. 00
57. 00   05700   CT   SCAN	144, 627	717, 171			864, 804	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	83, 264	484, 457	567, 721	1, 960	569, 681	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	38, 300	801, 040	1		839, 340	59. 00
60. 00 06000 LABORATORY	1, 610, 794	1, 939, 271	3, 550, 065	-84, 317	3, 465, 748	60.00
60. 01   06001   BL00D   LABORATORY 65. 00   06500   RESPI RATORY   THERAPY	224 024	104 577	429, 501	2, 627	0 432, 128	60. 01 65. 00
66. 00   06600 PHYSI CAL THERAPY	324, 924 1, 215, 249	104, 577 986, 098	1		2, 223, 713	66. 00
68. 00 06800 SPEECH PATHOLOGY	50, 345	3, 796			55, 335	
69. 00 06900 ELECTROCARDI OLOGY	180, 485	89, 847	1		270, 332	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 272, 721			1, 063, 227	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	C	4, 209, 494	4, 209, 494	72.00
73. 00   07300   DRUGS CHARGED TO PATLENTS 76. 00   03950   CARDI AC REHAB	124, 945	21, 702	146, 647	1, 980	0 148, 627	73. 00 76. 00
OUTPATIENT SERVICE COST CENTERS	124, 743	21, 702	140, 047	1, 700	140, 027	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0	89. 00
91. 00   09100   EMERGENCY	2, 164, 432	807, 871	2, 972, 303	33, 221	3, 005, 524	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	931, 495	240, 021	1, 171, 516	14, 854	1, 186, 370	101 00
SPECIAL PURPOSE COST CENTERS	70.17.70	210,021	1,1,1,010	, 1,700.1	17 1007 070	
113. 00 11300 I NTEREST EXPENSE		0	C	0		113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	C	0		114. 00
116. 00 11600 HOSPI CE	329, 817	491, 059			795, 101	
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	26, 040, 145	42, 272, 521	68, 312, 666	-651, 097	67, 661, 569	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	C	o	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	576, 157	679, 546	1, 255, 703	141, 352	1, 397, 055	192. 00
194. 00 07950 MCH	0	0	C	0		194. 00
194. 01 07951 RENTAL	0	0	C	34, 728	34, 728	
194. 02 07952 CMHS 194. 03 07953 MCH	0	0				194. 02 194. 03
194. 04 07954 WI C		0				194. 03
194. 05 07955 OTHER NONREIMBURSABLE COSTS		22, 861	22, 861	Ö	22, 861	
194.06 07956 RHC- FOREST RIDGE	4, 098, 069	1, 984, 795			6, 141, 667	
194. 07 07957 PHI LLI PS HALL	0	0	( C			194. 07
194. 08 07958 OB DRS	0	0	<u> </u>	0		194. 08
194. 09 07959 THE WATERS 194. 10 07960 CAMBRIDGE CITY	79, 008	0 149, 761	228, 769	409, 543 357	409, 543 229, 126	
194. 11 07961 WELL BEING	395, 841	222, 600			624, 755	
200. 00 TOTAL (SUM OF LINES 118-199)	31, 189, 220	45, 332, 084			76, 521, 304	
	· '		•		'	-

Provi der CCN: 15-0030

| Period: | Worksheet A | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: 2/15/2017 2:11 pm

			2/15/2017 2: 1	11 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00  00100 NEW CAP REL COSTS-BLDG & FIXT	-72, 168	4, 704, 776		1. 00
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP	0	743, 180		2. 00
3.00  00300 OTHER CAPITAL RELATED COSTS	0	0		3. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	1, 147, 006	8, 756, 892		4. 00
5.00   00500   ADMINISTRATIVE & GENERAL	-2, 512, 033	11, 640, 816		5. 00
7.00  00700 OPERATION OF PLANT	0	2, 677, 659		7. 00
8.00   00800   LAUNDRY & LINEN SERVICE	0	313, 933		8. 00
9. 00   00900   HOUSEKEEPI NG	0	683, 683		9. 00
10. 00  01000 DI ETARY	-100, 868	288, 340		10.00
11. 00  01100  CAFETERI A	-336, 820	161, 506		11. 00
13.00 01300 NURSING ADMINISTRATION	o	1, 906, 597		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	o	817, 488		14. 00
15. 00 01500 PHARMACY	-806, 174	2, 798, 203		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	-21, 815	837, 350		16. 00
INPATIENT ROUTINE SERVICE COST CENTERS		,		
30. 00 03000 ADULTS & PEDI ATRI CS	-3, 160	2, 919, 369		30.00
31.00 03100 INTENSIVE CARE UNIT	o	1, 254, 865		31.00
41. 00   04100   SUBPROVI DER -   RF	o	o		41.00
42. 00   04200   SUBPROVI DER	o	o		42. 00
43. 00 04300 NURSERY	o	568, 462		43.00
ANCILLARY SERVICE COST CENTERS	<u>'</u>	· · · ·		
50. 00 05000 OPERATING ROOM	0	2, 703, 948		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	102, 205		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-14, 553	1, 932, 288		54.00
57. 00 05700 CT SCAN	-483, 039	381, 765		57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	-322, 211	247, 470		58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	ol	839, 340		59. 00
60. 00   06000   LABORATORY	-25, 965	3, 439, 783		60.00
60. 01   06001   BLOOD   LABORATORY	0	0		60. 01
65. 00 06500 RESPI RATORY THERAPY	-11, 355	420, 773		65. 00
66. 00   06600   PHYSI CAL THERAPY	-742, 513	1, 481, 200		66. 00
68. 00 06800 SPEECH PATHOLOGY	7 12, 010	55, 335		68. 00
69. 00 06900 ELECTROCARDI OLOGY	o o	270, 332		69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o o	1, 063, 227		71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	o o	4, 209, 494		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		1, 207, 474		73. 00
76. 00 03950 CARDI AC REHAB	-106	148, 521		76.00
OUTPATIENT SERVICE COST CENTERS	- 100	140, 521		70.00
88. 00 08800 RURAL HEALTH CLINIC	O	O		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0		89. 00
91. 00   09100   EMERGENCY	-14, 357	2, 991, 167		91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	-14, 337	2, 991, 107		92.00
OTHER REIMBURSABLE COST CENTERS				92.00
101.00 10100 HOME HEALTH AGENCY	3, 047	1, 189, 417		101 00
SPECIAL PURPOSE COST CENTERS	3,047	1, 109, 417		101. 00
113. 00 11300 I NTEREST EXPENSE		O		112 00
	0	- 1		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	700 202		114. 00
116. 00 11600 HOSPI CE	4, 202	799, 303		116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	-4, 312, 882	63, 348, 687		118. 00
NONREI MBURSABLE COST CENTERS	1 0			100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	-110	1, 396, 945		192.00
194. 00 07950 MCH	0	0		194. 00
194. 01 07951 RENTAL	0	34, 728		194. 01
194. 02 07952 CMHS	0	0		194. 02
194. 03 07953 MCH	0	0		194. 03
194. 04 07954 WI C	0	0		194. 04
194.05 07955 OTHER NONREIMBURSABLE COSTS	0	22, 861		194. 05
194. 06 07956 RHC- FOREST RIDGE	0	6, 141, 667		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	409, 543		194. 09
194. 10 07960 CAMBRI DGE CLTY	0	229, 126		194. 10
194. 11 07961 WELL BEING	0	624, 755		194. 11
200.00 TOTAL (SUM OF LINES 118-199)	-4, 312, 992	72, 208, 312		200. 00

Provider CCN: 15-0030 

					10	5 Date/IIMe Prepare 2/15/2017 2:11 pm
		Increases			<u> </u>	27 107 2017 2111 5
	Cost Center	Li ne #	Salary	0ther		
	2.00 A - OB/NURSERY/L&D	3. 00	4. 00	5. 00		
. 00	NURSERY	43.00	503, 036	65, 426		1.
. 00	DELIVERY ROOM & LABOR ROOM	52.00	90, 442	11, 763		2.
	0		593, 478	77, 189		-
	B - CAFETERIA	<u>'</u>		,		
. 00	CAFETERI A	11. 00	278, 726	219, 600		1.
	0		278, 726	219, 600		
	C - WATERS EXCLUSIONS					
00	THE WATERS	194. 09	233, 347	176, 196		1.
00		0.00	0	0		2.
	D - DEPRECIATION POB		233, 347	176, 196		
00	RENTAL	194. 01	0	34, 728		1.
00	0			34, 728		'
	E - EQUIPMENT RENTAL		٥	01,720		
00	NEW CAP REL COSTS-MVBLE	2.00	0	743, 180		1.
	EQUI P			·		
00		0.00	0	0		2.
00		0.00	0	0		3.
00		0.00	0	0		4.
00		0.00	0	0		5.
00		0. 00 0. 00	O O	0		6.
00		0.00	0	0		8.
00		0.00	0	0		9.
00			<del> </del> _	743, 180		,
	F - IMPLANTABLE DEVICES		-,			
00	IMPL. DEV. CHARGED TO	72. 00	0	4, 209, 494		1.
	PATI ENT					
	0		0	4, 209, 494		
00	G - BONUS RECLASS EMPLOYEE BENEFITS DEPARTMENT	4.00	( )(4	0		1.
00	ADMINISTRATIVE & GENERAL	5.00	6, 264 136, 853	0		2.
00	OPERATION OF PLANT	7. 00	22, 519	o		3.
00	HOUSEKEEPI NG	9. 00	6, 234	Ö		4.
00	DI ETARY	10.00	12, 023	Ö		5.
00	NURSING ADMINISTRATION	13.00	41, 786	0		6.
00	CENTRAL SERVICES & SUPPLY	14. 00	11, 387	0		7.
00	MEDICAL RECORDS & LIBRARY	16. 00	11, 979	0		8.
00	ADULTS & PEDIATRICS	30.00	53, 142	0		9.
0. 00	INTENSIVE CARE UNIT	31. 00	17, 295	0		10.
. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	33, 923 28, 218	0		11.
3. 00	CT SCAN	57. 00	3, 006	0		13
. 00	MAGNETIC RESONANCE I MAGING	58.00	1, 960	0		14.
	(MRI)	33.33	.,,,,,,			
. 00	LABORATORY	60.00	34, 183	0		15.
b. 00	RESPI RATORY THERAPY	65. 00	6, 025	0		16
. 00	PHYSI CAL THERAPY	66. 00	22, 881	0		17
. 00	SPEECH PATHOLOGY	68. 00	1, 194	0		18
. 00	CARDI AC REHAB	76.00	1, 980	0		19
0.00	EMERGENCY	91.00	33, 221	0		20
. 00	HOME HEALTH AGENCY	101.00	15, 170	0		21
. 00	HOSPICE PHYSICIANS' PRIVATE OFFICES	116. 00 192. 00	3, 912 141, 511	0		22 23
. 00	RHC- FOREST RIDGE	192.00	58, 803	0		24
. 00	CAMBRI DGE CI TY	194. 10	357	o		25
	WELL BEING	194. 11	6, 314			26
. 00			712, 140	<u>0</u>		23
. 00						
. 00	H - PHYSICIAN EMPLOYEE BENEFIT	-				
00	H - PHYSICIAN EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT TOTALS	4.00	0	11 <u>8, 5</u> 00 118, 500		1.

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0030 Peri od: Worksheet A-6 | Period: | Worksheet A-6 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

					Т	o 12/31/2015	Date/Time Prepar 2/15/2017 2:11 p
		Decreases					27 137 2017 2. 11 p
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	- OB/NURSERY/L&D	20.00	E02 470	77 100			
00 AE	DULTS & PEDIATRICS	30. 00 0. 00	593, 478	77, 189 0			1 2
			593, 478	77, 189			
B	- CAFETERI A		373, 470	77, 107			
	ETARY	10.00	278, 726	219, 600	0		
0		<u> </u>	278, 726	219, 600			
С	- WATERS EXCLUSIONS	· · · · · · · · · · · · · · · · · · ·		•	'		
	OUSEKEEPI NG	9. 00	37, 874	22, 189	0		1
00 DI	ETARY	10.00	195, 473	154, 007	o		2
0			233, 347	176, 196			
	- DEPRECIATION POB						
I	EW CAP REL COSTS-BLDG &	1.00	0	34, 728	9		1
FI		+	+	, ,			
0			0	34, 728			
	- EQUI PMENT RENTAL	7 00		45			
	PERATION OF PLANT	7.00	0	45			1
	HARMACY	15.00	0	138, 821 292, 476			2
	PERATING ROOM ADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0				3
	ESPI RATORY THERAPY	65. 00	0	277, 763 3, 398			5
	HYSI CAL THERAPY	66.00	0	515	1		
	DME HEALTH AGENCY	101.00	0	316			5
	OSPI CE	116.00	0	29, 687			8
	HYSICIANS' PRIVATE OFFICES	192.00	Ö	159			Ģ
0				743, 180			,
F	- IMPLANTABLE DEVICES	,	-,				
00 ME	EDICAL SUPPLIES CHARGED TO	71.00	0	4, 209, 494	0		1
PA	ATIENTS						
0			0	4, 209, 494			
	- BONUS RECLASS				1		
	MPLOYEE BENEFITS DEPARTMENT	4.00	712, 140	0			1
00		0.00	0	0			2
00		0.00	0	0			3
00		0.00	0	0			4
00		0. 00 0. 00	O O	0			5
00		0.00	0	0			6
00		0.00	0	0			8
00		0.00	0	0			
. 00		0.00	0	0			10
. 00		0.00	Ö	0			11
. 00		0.00	ő	0	_		12
. 00		0.00	ő	0	_		13
. 00		0.00	ó	0			14
. 00		0.00	0	0	o		15
. 00		0.00	0	0	0		16
. 00		0.00	0	0	0		17
. 00		0.00	0	0			18
00		0.00	О	0			19
00		0.00	0	0	0		20
00		0.00	0	0			21
00		0.00	0	0			22
00		0.00	0	0			23
00		0.00	0	0			24
00		0.00	0	0	_		25
. 00	+	0.00	0	0			26
0	DIVELCIAN ENDLOYEE DEVECT	Т	712, 140	0			
	- PHYSICIAN EMPLOYEE BENEFI		ما	110 500			
	ABORATORY DTALS	60.00	0	11 <u>8, 5</u> 00 118, 500			1
	21/16-2	1	٧	1 10, 300			500

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0030 Peri od: Worksheet A-7 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 2/15/2017 2:11 pm Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 46,000 0 1.00 0 2.00 Land Improvements 1,621,597 0 2.00 36, 392, 851 3.00 3.00 Buildings and Fixtures 4, 684, 124 4, 684, 124 0 0 4.00 Building Improvements 205, 296 0 4.00 5.00 Fixed Equipment 15, 735, 005 54, 316 0 54, 316 5.00 0 6.00 Movable Equipment 31, 891, 147 3, 098, 823 3, 098, 823 539, 936 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 85, 891, 896 7, 837, 263 7, 837, 263 539, 936 8.00 9.00 Reconciling Items 0 9.00 85, 891, 896 7<u>, 837, 263</u> 7, 837<u>,</u> 263 539, 936 Total (line 8 minus line 9) 10.00 0 10.00 Endi ng Bal ance Fully 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 Land Improvements 1, 621, 597 0 2.00 3.00 Buildings and Fixtures 41, 076, 975 0 3.00 0 4.00 Building Improvements 205, 296 4.00 5.00 Fi xed Equipment 15, 789, 321 0 5.00 Movable Equipment 0 6.00 34, 450, 034 6.00

93, 189, 223

93, 189, 223

0

0

0

7.00

8.00

9.00

10.00

7.00

8.00

9.00

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

Heal th	Financial Systems HI	ENRY COUNTY MEM	IORIAL HOSPITAL	_	In Lie	u of Form CMS-	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
					From 01/01/2015 Fo 12/31/2015	Part II   Date/Time Pre	nared:
				'	10 12/31/2013	2/15/2017 2: 1	
			S	UMMARY OF CAPI	TAL		
				T .	1.		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
	DART III DEGGNOLLIATION OF MIGHNES FROM WORK	9.00	10.00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			and 2	_	_	
1.00	NEW CAP REL COSTS-BLDG & FIXT	4, 553, 139	(	258, 533	3 0	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	(		0	0	2. 00
3.00	Total (sum of lines 1-2)	4, 553, 139		258, 533	3 0	0	3. 00
		SUMMARY 0	F CAPITAL				
			L				
	Cost Center Description		Total (1) (sum	n			
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)		4			
	DART III DECONOLILIATION OF ANOUNTO FROM WORK	14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	·				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	4, 811, 672	2			1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	(	)			2. 00
3.00	Total (sum of lines 1-2)	0	4, 811, 672	2			3.00

Heal th	Financial Systems HI	ENRY COUNTY MEN	MORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2015 To 12/31/2015	Worksheet A-7 Part III Date/Time Pre 2/15/2017 2:1	pared:
		COM	PUTATION OF RAT	TI 0S	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI					2.22	
1.00	NEW CAP REL COSTS-BLDG & FIXT	42, 273, 949	0	42, 273, 94	9 0. 455938	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	50, 444, 651		50, 444, 65			2. 00
3.00	Total (sum of lines 1-2)	92, 718, 600		92, 718, 60			3. 00
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DADT III DECONCILIATION OF CADITAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CINEW CAP REL COSTS-BLDG & FIXT	ENTERS			0 4, 518, 411	0	1. 00
2.00	NEW CAP REL COSTS-BLDG & FIXT	0			0 743, 180		2.00
3.00	Total (sum of lines 1-2)				0 5, 261, 591		3. 00
0.00	Total (Sam of Titles 1 2)		SI	JMMARY OF CAPI		0	0.00
			-				
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11.00	12.00	13.00	instructions) 14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		12.00	13.00	14.00	13.00	
1. 00	NEW CAP REL COSTS-BLDG & FLXT	186, 365	0		0 0	4, 704, 776	1.00
2. 00	NEW CAP REL COSTS-MVBLE EQUIP	0		•	o o	743, 180	
3. 00	Total (sum of lines 1-2)	186, 365	0		0 0	5, 447, 956	
		•	•	•	•		•

	Financial Systems MENTS TO EXPENSES	HEN	NRY COUNTY MEM	ORIAL HOSPITAL Provider CCN: 15-0030	Peri od:	u of Form CMS-2 Worksheet A-8	
					From 01/01/2015 To 12/31/2015	Date/Time Pre 2/15/2017 2:1	
				Expense Classification To/From Which the Amount i		271372017 2.1	рш
	Cost Center Description		Amount	Cost Center 3.00	Li ne #	Wkst. A-7 Ref.	
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	1. 00 A		NEW CAP REL COSTS-BLDG &	1.00	5. 00 11	1. 00
2. 00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	2)   Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time	В	-13, 284	ADMINISTRATIVE & GENERAL	5. 00	0	4. 00
5.00	di scounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6.00	expenses (chapter 8) Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Tel ephone services (pay stations excluded) (chapter 21)	А	-20, 123	ADMINISTRATIVE & GENERAL	5.00	0	7. 00
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -4, 917		0.00	0 0	
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	1	A-8-1	-1, 551, 968			0	12. 00
13. 00 14. 00 15. 00	Laundry and linen service Cafeteria-employees and guests Rental of quarters to employee	В	0 -336, 820 0	CAFETERI A	0. 00 11. 00 0. 00	0 0 0	14. 00
16. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
18. 00	I and the second	В	-21, 815	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0. 00	0	19. 00
	books, etc.) Vending machines		0		0.00		
	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114.00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1.00	0	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - NEW CAP REL		0	FIXT NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist			EQUIP *** Cost Center Deleted **			28. 00
29. 00 30. 00	therapy costs in excess of	A-8-3	0	*** Cost Center Deleted **	0. 00 67. 00		29. 00 30. 00
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00

Provi der CCN: 15-0030 Peri od: Worksheet A-8 From 01/01/2015 | Worksheet A-8 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

				Te	12/31/2015		
				Expense Classification on	Workshoot A	2/15/2017 2: 1	I DIII
				To/From Which the Amount is			
				TOTT OIL MITTER THE THIOGRAPH TS	to be haj astea		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2.00	3. 00	4. 00	5. 00	
33.00	OTHER OP REV - HUMAN RESOURSEC	В	-358	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
	- MIS						
34. 00	OTHER OP REV	В	•	ADMINISTRATIVE & GENERAL	5. 00		
35. 00	OTHER OP REV - COPI ES RECEI PTS			ADMINISTRATIVE & GENERAL	5. 00		35. 00
36. 00	OTHER OP REV - PHY REAPP FEES	В	•	ADMINISTRATIVE & GENERAL	5. 00		36. 00
36. 01	OTHER OP REV - DIETARY -	В	-75, 554	DI ETARY	10. 00	0	36. 01
20.00	OUTSIDE SAL	В	25 214	DLETADY	10.00		20.00
38. 00	OTHER OP REV - DIETARY TRANSFERS	В	-25, 314	DIETARY	10.00	0	38. 00
38. 01	OTHER OP REV - PHARMACY	В	906 174	PHARMACY	15. 00	0	38. 01
40. 00	OTHER OF REV - PCU - HLTH PROG		•	ADULTS & PEDIATRICS	30.00		40.00
40.00	REC	ь	-040	ADULIS & FEDIATRICS	30.00	0	40.00
40. 01	OTHER OP REV - WOMEN & CH	В	-28	ADULTS & PEDIATRICS	30.00	0	40. 01
40.01	UNIT- HLTH	, b	20	ADOLTS & TEDIATRICS	30.00		40.01
40. 02	OTHER OP REV - LAB-LAB DRUG	В	-24, 092	LABORATORY	60.00	0	40. 02
	SCREEN						
40. 03	OTHER OP REV-LABORATORY	В	3, 044	LABORATORY	60.00	0	40. 03
41.00	OTHER OP REV - ATH TRAINING -	В		PHYSICAL THERAPY	66.00	0	41.00
	HLTH P						
42.00	OTHER OP REV - ATH TRAINING -	В	-7, 645	PHYSICAL THERAPY	66.00	0	42. 00
	OUTSI D						
43.00	OTHER OP REV - AQUATICS - HLTH	В	-20, 952	PHYSICAL THERAPY	66.00	0	43. 00
	PROG	_					
44. 00	OTHER OP REV - PHYSICAL THER	В		PHYSI CAL THERAPY	66.00		
44. 01	OTHER OP REV - PHYSICAL THER -	В	-630	PHYSI CAL THERAPY	66. 00	0	44. 01
45.00	HLTH		0.400	DINGLOAL TUEDADY	// 00		45.00
45. 00	OTHER OP REV - PHYSICAL THER -	В	-9, 430	PHYSI CAL THERAPY	66. 00	0	45. 00
45. 01	EE OTHER OP REV - PHYSICAL THER -	В	E0 200	PHYSICAL THERAPY	66.00	0	45. 01
43. 01	FIT F	D	-30, 390	PHISICAL INERAPI	00.00	0	45.01
45. 02	PUBLIC RELATIONS	Α	-650	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	45. 02
45. 02	PUBLIC RELATIONS	A		ADMINISTRATIVE & GENERAL	5. 00		•
45. 04	PUBLIC RELATIONS	A	•	ADULTS & PEDIATRICS	30.00		45. 04
45. 05	PUBLIC RELATIONS	A		RADI OLOGY-DI AGNOSTI C	54.00		
45. 06	PUBLIC RELATIONS	A	•	RESPIRATORY THERAPY	65. 00		45. 06
45. 07	PUBLIC RELATIONS	A		PHYSI CAL THERAPY	66.00		
45. 08	PUBLIC RELATIONS	A		CARDI AC REHAB	76. 00		45. 08
45. 09	PUBLIC RELATIONS	A		EMERGENCY	91. 00		
45. 10	PUBLIC RELATIONS	A	•	HOME HEALTH AGENCY	101. 00		45. 10
45. 11	PUBLIC RELATIONS	A		HOSPI CE	116. 00		45. 11
45. 12	PUBLIC RELATIONS	A		PHYSICIANS' PRIVATE OFFICES	192. 00		45. 12
45. 13	AHA & IHA DUES	A		ADMINISTRATIVE & GENERAL	5. 00		45. 13
45. 14	BENEFIT EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00		45. 14
45. 15	HOSPITALIST EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00		45. 15
45. 16	HAF EXPENSE	A	•	ADMINISTRATIVE & GENERAL	5. 00		45. 16
45. 17			0		0.00		45. 17
45. 18	OTHER ADJUSTMENTS (SPECIFY)		0		0.00		45. 18
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		-4, 312, 992				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						L

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

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

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

B. Amount Received - if cost cannot be determined.

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

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

				To 12/31/2015	Date/Time Pre 2/15/2017 2:1	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	54. 00	RADI OLOGY-DI AGNOSTI C	XRAY	5, 528	18, 964	1.00
2.00	57. 00	CT SCAN	CT SCAN	175, 711	658, 750	2.00
3.00	58. 00	MAGNETIC RESONANCE IMAGING (	MRI	127, 789	450, 000	3.00
4.00	66.00	PHYSI CAL THERAPY	PHYSI CAL THERAPY	214, 025	786, 328	4.00
4 01	5 00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	1 0	159 140	4 01

\* 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.

HOSPI CE

RESPIRATORY THERAPY

HOME HEALTH AGENCY

39, 937

6,520

6,520

2, 126, 159

4 02

4.03

4.04

5 00

28 764

11, 189

11, 185

574, 1<sub>91</sub>

			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 RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	G	HENRY COUNTY HO	100.00 HOSPITAL FOUNDATION	0.00	6. 00
7.00			0.00	0.00	7. 00
8.00			0.00	0.00	8. 00
9.00			0.00	0.00	9. 00
10.00			0.00	0.00	10. 00
100.00	G. Other (financial or	MI SC			100.00
	non-financial) specify:				

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

65. 00 RESPIRATORY THERAPY

101.00 HOME HEALTH AGENCY

116. 00 HOSPI CE

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

4 02

4.03

4.04

5.00

Health Financial Systems			ŀ	HENRY COUNTY MEMOR	In Lieu of Form CMS-2552-10			
STATEME OFFICE		SERVICES FROM	N RELATED ORGANI	ZATIONS AND HOME	Provider CCN: 15-0030	Peri od: From 01/01/2015 To 12/31/2015	Worksheet A-8	
							2/15/2017 2:1	
	Net	Wkst. A-7 Ref						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
	A. COSTS INCUR	RED AND ADJUST	TMENTS REQUIRED	AS A RESULT OF TRA	ANSACTIONS WITH RELATED (	ORGANIZATIONS OR (	CLAIMED	
	HOME OFFICE CO	STS:						
1.00	-13, 436		0					1.00
2.00	-483, 039		o					2. 00
3.00	-322, 211		o					3. 00
4.00	-572, 303		o					4. 00
4. 01	-159, 140		ol					4. 01
4. 02	-11, 173		ol					4. 02

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 par

4.03

4.04

5 00

nas not	been posted to worksheet A,	cordinas i and/or 2, the amount arrowable should be marcated in cordinar 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	3.		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	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
10. 00 100. 00		10.00
100.00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- 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 provi der

-1, 551, 968

4,669

4,665

4.03

4.04

5.00

0

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

					-	To 12/31/2015	Date/Time Pre 2/15/2017 2:1	epared:
	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		LABORATORY	80, 004		,	260, 300	600	1. 00
2.00	0. 00		0		0	0	1	
3. 00	0. 00		0	0	0	0	0	3. 00
4. 00	0. 00		0	0	0	0	0	4. 00
5. 00	0. 00		0	0	0	0	0	5. 00
6.00	0. 00		0	0	0	0	0	6. 00
7. 00	0. 00		0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10. 00
200.00		0 1 0 1 (5)	80, 004		80, 004			200. 00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE Limit	Continuing	Component Share of col.	of Malpractice Insurance	
				LIIIII	Education	12	i risurance	
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14. 00	
1. 00		LABORATORY	75, 087	3, 754				1. 00
2. 00	0.00	EABORATORT	73,007			1		2. 00
3. 00	0.00		0	1		0	ĺ	3. 00
4. 00	0.00		0	0	0	0	0	4. 00
5. 00	0.00		0	0	0	0	o o	5. 00
6. 00	0.00		Ö	Ö	0	Ö	0	6. 00
7. 00	0.00		0	0	0	0	0	
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			75, 087	3, 754	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		LABORATORY	0		·	4, 917		1. 00
2. 00	0. 00		0	0	0	0		2. 00
3. 00	0. 00		0	0	0	0		3. 00
4. 00	0. 00		0	0	0	0		4. 00
5. 00	0.00		0	0	0	0		5. 00
6. 00	0.00		0	0	0	0		6. 00
7.00	0.00		0	0	0	0		7. 00
8. 00	0.00				0			8. 00
9.00	0.00							9. 00
10.00	0. 00			75.007	4 017	0 4 017		10.00
200.00			l 0	75, 087	4, 917	4, 917	I	200. 00

| Period: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0030

			T.	o 12/31/2015	Date/Time Pre	
		CAPITAL RELATED COSTS			2/15/2017 2:1	1 pm
Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
	Allocation	FIAI	EQUIP	DEPARTMENT		
	(from Wkst A			DEI / IKTIMEIVT		
	col . 7)					
GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	4A	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT	4, 704, 776	4, 704, 776				1. 00
2.00 OO200 NEW CAP REL COSTS-MVBLE EQUIP	743, 180		743, 180			2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	8, 756, 892	24, 729		8, 785, 270		4. 00
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT	11, 640, 816	526, 900	77, 755	1, 617, 555	13, 863, 026	5. 00
7.00   00700   OPERATION OF PLANT 8.00   00800   LAUNDRY & LINEN SERVICE	2, 677, 659 313, 933	1, 250, 958 62, 158		286, 329	4, 399, 551 385, 264	7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG	683, 683	37, 720		123, 045	850, 014	9. 00
10. 00   01000   DI ETARY	288, 340	131, 148	19, 354	63, 307	502, 149	10.00
11. 00   01100   CAFETERI A	161, 506	35, 830		79, 130	281, 754	11.00
13. 00   01300   NURSI NG ADMINI STRATI ON 14. 00   01400   CENTRAL SERVI CES & SUPPLY	1, 906, 597 817, 488	66, 664 129, 967	9, 838 19, 179	454, 464 121, 627	2, 437, 563 1, 088, 261	13. 00 14. 00
15. 00 01500 PHARMACY	2, 798, 203	28, 381	4, 188		2, 830, 772	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	837, 350	96, 317	14, 214	172, 175	1, 120, 056	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	T					
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   NTENSIVE CARE UNIT	2, 919, 369 1, 254, 865	534, 822 210, 785	78, 924 31, 106	739, 119 325, 210	4, 272, 234 1, 821, 966	30. 00 31. 00
41. 00   04100   SUBPROVI DER -   I RF	1, 254, 865	210, 783	0	323, 210	1, 821, 400	41.00
42. 00   04200   SUBPROVI DER	o	0	0	O	0	42. 00
43. 00 04300 NURSERY	568, 462	55, 744	8, 226	142, 811	775, 243	43. 00
ANCI LLARY SERVI CE COST CENTERS  50. 00 OPERATI NG ROOM	2, 703, 948	295, 692	43, 635	553, 308	3, 596, 583	50. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	102, 205	28, 326	43, 633	25, 676	160, 387	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 932, 288	205, 716	30, 358	415, 920	2, 584, 282	54. 00
57. 00 05700 CT SCAN	381, 765	7, 958	1, 174	41, 913	432, 810	57. 00
58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI)	247, 470	9, 721	1, 434	24, 195	282, 820	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	839, 340 3, 439, 783	88, 413 150, 099	13, 047 22, 150	10, 873 467, 007	951, 673 4, 079, 039	59. 00 60. 00
60. 01   06001   BLOOD   LABORATORY	0, 107, 700	0	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	420, 773	31, 542	4, 655	93, 956	550, 926	65. 00
66. 00   06600   PHYSI CAL THERAPY	1, 481, 200	22, 657	3, 344	351, 504	1, 858, 705	66. 00
68. 00   06800  SPEECH PATHOLOGY 69. 00   06900  ELECTROCARDI OLOGY	55, 335 270, 332	3, 507 0	517 0	14, 632 51, 240	73, 991 321, 572	68. 00 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 063, 227	0	ő	0	1, 063, 227	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	4, 209, 494	0	0	O	4, 209, 494	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	12.010	0	0	100, 200	73. 00
76. 00 03950 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS	148, 521	12, 919	1, 906	36, 034	199, 380	76. 00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	О	0	89. 00
91. 00 09100 EMERGENCY	2, 991, 167	192, 016	28, 336	623, 911	3, 835, 430	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92. 00
101.00 10100 HOME HEALTH AGENCY	1, 189, 417	0	0	268, 757	1, 458, 174	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300   NTEREST EXPENSE						113.00
114.00   11400   UTI LI ZATI ON REVI EW-SNF 116.00   11600   HOSPI CE	799, 303	0	0	94, 745	894, 048	114. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	63, 348, 687	4, 240, 689	625, 801	7, 198, 443	61, 180, 394	
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 204 045	18, 333		0	18, 333	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 396, 945	0	0	203, 745	1, 600, 690	192. 00 194. 00
194. 01 07951 RENTAL	34, 728	Ö	51, 599	Ö	86, 327	
194. 02 07952 CMHS	o	0	0	0		194. 02
194. 03 07953 MCH	0	0	0	0		194. 03
194. 04 07954 WIC 194. 05 07955 OTHER NONREIMBURSABLE COSTS	22, 861	0	)   0	0	22, 861	194. 04 194. 05
194. 06 07956 RHC- FOREST RIDGE	6, 141, 667	0	ő	1, 180, 132	7, 321, 799	
194. 07 07957 PHI LLI PS HALL	0	0	0	0	0	194. 07
194. 08 07958 OB DRS	0	445 35	0	0		194. 08
194.09 07959 THE WATERS 194.10 07960 CAMBRIDGE CITY	409, 543 229, 126	445, 754 0	65, 780 0	66, 247 22, 532	987, 324 251, 658	
194.11 07961 WELL BEING	624, 755	ol	Ö	114, 171	738, 926	
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers	70 000 000	0	0	0 705 073		201. 00
202.00   TOTAL (sum lines 118-201)	72, 208, 312	4, 704, 776	743, 180	8, 785, 270	72, 208, 312	ZUZ. UU

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0030

Peri od: Worksheet B From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared:

2/15/2017 2:11 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 13.863.026 5 00 5 00 7.00 00700 OPERATION OF PLANT 1,045,347 5, 444, 898 7.00 00800 LAUNDRY & LINEN SERVICE 91, 540 615, 311 8.00 138, 507 8.00 9.00 00900 HOUSEKEEPI NG 201, 966 84, 052 26, 048 1.162.080 9.00 01000 DI ETARY 292, 238 119, 312 943, 383 10.00 10.00 6.996 22, 688 01100 CAFETERI A 66, 946 79, 841 0 7, 779 11.00 11.00 0 13 00 01300 NURSING ADMINISTRATION 579, 172 148, 548 0 13, 397 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 258.574 289, 606 0 13, 397 14 00 0 15.00 01500 PHARMACY 672,600 63, 241 0 6, 698 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 266, 129 214, 623 9.508 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 1, 015, 096 1, 191, 743 123, 963 286, 523 724 237 31.00 03100 INTENSIVE CARE UNIT 432, 905 469, 694 27, 936 44, 513 219, 146 31.00 04100 SUBPROVI DER - I RF 41.00 41.00 04200 SUBPROVI DER 42.00 42.00 0 0 0 04300 NURSERY 43.00 184, 200 124, 215 10, 362 3,889 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 854, 559 658, 891 110, 367 101, 558 n 50.00 05200 DELIVERY ROOM & LABOR ROOM 63, 120 52.00 38, 108 1, 862 8, 211 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 614, 033 458, 398 44, 669 66, 769 0 54.00 57.00 05700 CT SCAN 102.837 17, 733 C 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 67, 199 21, 661 58.00 58.00 0 0 0 05900 CARDIAC CATHETERIZATION 59 00 226, 120 197, 011 1, 457 12, 533 Λ 59 00 60.00 06000 LABORATORY 969, 192 334, 466 776 30,035 0 60.00 06001 BLOOD LABORATORY 60.01 C 0 60.01 06500 RESPIRATORY THERAPY 130, 902 70. 286 25. 065 65.00 0 0 65.00 06600 PHYSI CAL THERAPY 66.00 441,634 50, 488 13, 519 137, 211 0 66.00 68.00 06800 SPEECH PATHOLOGY 17,580 7,814 C 0 68.00 06900 ELECTROCARDI OLOGY 69.00 76, 406 0 4, 322 0 69.00 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 252, 626 O 0 71 00 Ω 0 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 1,000,188 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 73.00 C 76.00 03950 CARDI AC REHAB 47, 373 0 0 76.00 0 0 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 Ω 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 89.00 91 00 09100 EMERGENCY 427 870 109, 963 91 00 911, 310 74.764 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 346, 467 0 0 11, 884 0 101. 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 212, 428 0 116.00 SUBTOTALS (SUM OF LINES 1-117) 118.00 11, 242, 749 477, 918 943, 383 118. 00 5, 404, 046 880.744 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 4.356 40.852 2.809 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 380, 329 305 194 00 07950 MCH C C 0 194 00 194. 01 07951 RENTAL 20, 512 0 0 194. 01 256, 271 194. 02 07952 CMHS 0 0 0 194. 02 194. 03 07953 MCH 0 194. 03 0 0 0 0 194. 04 194. 04 07954 WIC Λ 0 194. 05 07955 OTHER NONREIMBURSABLE COSTS 12, 998 0 0 194. 05 5, 432 194.06 07956 RHC- FOREST RIDGE 0 194.06 1, 739, 691 3, 816 0 194. 07 07957 PHI LLI PS HALL 0 194, 07 0 4.985 22, 256 194. 08 07958 OB DRS C 8, 237 0 194. 08 0 194. 09 07959 THE WATERS 234, 591 107, 052 0 0 194. 09 194. 10 07960 CAMBRIDGE CITY 0 194. 10 59.795 0 0 C 194. 11 07961 WELL BEING 175, 571 0 0 0 194, 11 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118-201) 13, 863, 026 5.444.898 615. 311 1. 162. 080 943, 383 202. 00 202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0030

Peri od: Worksheet B From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared:

			10	12/31/2015	Date/IIme Pre   2/15/2017 2:1	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	ļ piii
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 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   ADMI NI STRATI VE & GENERAL						5.00
7.00   00700   OPERATION OF PLANT 8.00   00800   LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10.00
11. 00   01100   CAFETERI A	436, 320					11. 00
13.00 01300 NURSING ADMINISTRATION	28, 198	3, 206, 878				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	11, 863	0	1, 661, 701			14. 00
15. 00   01500   PHARMACY	0	0	2, 741	3, 576, 052		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	20, 855	0	3, 051	0	1, 634, 222	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	72, 902	1, 024, 135	20, 000	٥	227 025	30.00
31. 00   03100   NTENSI VE CARE UNIT	27, 267	383, 058	29, 889 6, 744	0	227, 825 94, 531	31.00
41. 00   04100   SUBPROVI DER	27,207	303, 030	0, 744	0	0	41.00
42. 00   04200   SUBPROVI DER	o o	o o	Ö	o	0	42. 00
43. 00   04300   NURSERY	12, 015	168, 794	0	0	51, 686	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	56, 412		87, 322	0	238, 027	50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	2, 153	30, 241	0	0	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 57. 00   05700   CT   SCAN	39, 572	0	42, 327	0	184, 981	54. 00 57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	3, 481 2, 412	0	10, 895 3, 863	0	57, 806 31, 283	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	809	0	0,000	0	8, 841	
60. 00   06000   LABORATORY	53, 924	o	208, 440	o	235, 986	1
60. 01   06001   BL00D   LABORATORY	0	o	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	8, 473	0	3, 196	0	18, 362	65. 00
66. 00 06600 PHYSI CAL THERAPY	33, 466	0	8, 160	0	20, 402	66. 00
68. 00   06800   SPEECH PATHOLOGY	931	0	20	0	680	68. 00
69. 00 06900 ELECTROCARDI OLOGY	4, 061	0	4, 776	0	21, 082	69. 00 71. 00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00   07200   IMPL. DEV. CHARGED TO PATIENT	0	0	243, 873 965, 534	0	78, 209 71, 408	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	703, 334	3, 576, 052	71, 400	73. 00
76. 00   03950   CARDI AC   REHAB	3, 908	54, 906	1, 814	0	2, 040	76. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
91.00   09100   EMERGENCY 92.00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)	53, 618	753, 247	31, 804	0	269, 311	
92. 00   O9200   OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
101. 00 10100 HOME HEALTH AGENCY	0	0	4, 572	ol	10, 881	101.00
SPECIAL PURPOSE COST CENTERS		-	., =	-1		
113. 00 11300   NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
116. 00 11600 H0SPI CE	0		2, 680	0	10, 881	
118. 00 SUBTOTALS (SUM OF LINES 1-117)	436, 320	3, 206, 878	1, 661, 701	3, 576, 052	1, 634, 222	1118. 00
NONREIMBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		٥	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0		0	0		192. 00
194. 00 07950 MCH	Ö		Ö	Ö		194. 00
194. 01 07951 RENTAL	0	o	0	0		194. 01
194. 02 07952 CMHS	0	o	0	0	0	194. 02
194. 03 07953 MCH	0	0	0	0		194. 03
194. 04 07954 WI C	0	0	0	0		194. 04
194. 05 07955 OTHER NONREIMBURSABLE COSTS 194. 06 07956 RHC- FOREST RIDGE	0		0	0		194. 05 194. 06
194.06 07956 RHC- FOREST RTDGE 194.07 07957 PHILLIPS HALL		ا		0		194. 06
194. 08 07958 0B DRS	0	0	0	0		194. 07
194. 09 07959 THE WATERS	0	Ö	o	ol		194. 09
194. 10 07960 CAMBRI DGE CITY	0	o	O	o		194. 10
194. 11 07961 WELL BEING	0	0	0	O	0	194. 11
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0 204 070	0	0		201. 00
202.00   TOTAL (sum lines 118-201)	436, 320	3, 206, 878	1, 661, 701	3, 576, 052	1, 634, 222	<sub>1</sub> 202. 00

| Period: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0030

					o 12/31/2015 Date/Time	
	Cost Center Description	Subtotal	Intern &	Total	2/15/2017	2: 11 pm
	<u>'</u>		Residents Cost			
			& Post			
			Stepdown Adjustments			
		24.00	25. 00	26. 00		
4 00	GENERAL SERVICE COST CENTERS	1	1		I	
1. 00 2. 00	OO100 NEW CAP REL COSTS-BLDG & FIXT   OO200 NEW CAP REL COSTS-MVBLE EQUIP					1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
7.00	00700 OPERATION OF PLANT					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 10. 00	00900   HOUSEKEEPI NG   01000   DI ETARY					9. 00 10. 00
11. 00	01100 CAFETERI A					11. 00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14.00	01400 CENTRAL SERVI CES & SUPPLY					14. 00
15. 00 16. 00	01500   PHARMACY   01600   MEDI CAL RECORDS & LI BRARY					15. 00 16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					10.00
30.00	03000 ADULTS & PEDI ATRI CS	8, 968, 547	0	8, 968, 547		30. 00
31.00	03100 I NTENSI VE CARE UNI T	3, 527, 760		3, 527, 760		31. 00
41. 00	04100 SUBPROVI DER - I RF	0	0	0		41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	1, 330, 404	0	1, 330, 404		42. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	1, 330, 404	<u> </u>	1, 330, 404	l .	43.00
50.00	05000 OPERATI NG ROOM	6, 496, 216	1	6, 496, 216		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	304, 082	1	304, 082		52.00
54. 00 57. 00	05400  RADI OLOGY-DI AGNOSTI C   05700  CT SCAN	4, 035, 031 625, 562	0	4, 035, 031 625, 562		54. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	409, 238	1 1	409, 238		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 398, 444	0	1, 398, 444		59. 00
60.00	06000 LABORATORY	5, 911, 858	1	5, 911, 858		60. 00
60. 01 65. 00	06001   BLOOD LABORATORY   06500   RESPI RATORY THERAPY	807, 210	0	807, 210		60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 563, 585	i i	2, 563, 585		66. 00
68. 00	06800 SPEECH PATHOLOGY	101, 016	1	101, 016		68. 00
69. 00	06900 ELECTROCARDI OLOGY	432, 219	1	432, 219		69. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	1, 637, 935	1	1, 637, 935		71. 00 72. 00
72.00	07300 DRUGS CHARGED TO PATIENTS	6, 246, 624 3, 576, 052		6, 246, 624 3, 576, 052		73. 00
76. 00	03950 CARDI AC REHAB	309, 421	Ö	309, 421		76. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC	0	1	0		88. 00
89. 00 91. 00	08900  FEDERALLY QUALIFIED HEALTH CENTER   09100  EMERGENCY	6, 467, 317	-1	6, 467, 317		89. 00 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,407,317	0	0, 407, 317		92. 00
	OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY	1, 831, 978	0	1, 831, 978		101. 00
113 00	SPECIAL PURPOSE COST CENTERS  11300 INTEREST EXPENSE					113. 00
	11400 UTI LI ZATI ON REVI EW-SNF					114. 00
	11600 H0SPI CE	1, 120, 037	1	1, 120, 037		116. 00
118. 00		58, 100, 536	0	58, 100, 536		118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	66, 350	O	66, 350		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	1, 981, 324	1	1, 981, 324		192. 00
	07950 MCH	0	O	0		194. 00
	07951 RENTAL	363, 110	0	363, 110		194. 01
	07952 CMHS 07953 MCH		0	0		194. 02 194. 03
	07954 WI C		0	0		194. 04
194. 05	07955 OTHER NONREIMBURSABLE COSTS	41, 291	0	41, 291		194. 05
	07956 RHC- FOREST RIDGE	9, 065, 306	1	9, 065, 306		194. 06
	07957	27, 241 8, 237	0	27, 241 8, 237		194. 07 194. 08
	07959 THE WATERS	1, 328, 967	-1	1, 328, 967		194. 08
194. 10	07960 CAMBRIDGE CITY	311, 453	0	311, 453		194. 10
	07961 WELL BEING	914, 497		914, 497		194. 11
200. 00 201. 00	1	0	0	0		200. 00 201. 00
201.00		72, 208, 312		72, 208, 312		201.00
_52.50	, ( 20.)	,,,	١	, _555, 512	ı	1=52.00

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0030

			То	12/31/2015	Date/Time Pre 2/15/2017 2:1	
		CAPI TAL REL	ATED COSTS		2/15/2017 2.1	ı piii
Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	Assigned New	FLXT	EQUI P		BENEFITS DEPARTMENT	
	Capi tal Related Costs				DEPARTMENT	
	0	1.00	2.00	2A	4. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	0	24, 729		28, 378	28, 378	4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	0	526, 900	77, 755	604, 655	5, 230	5. 00
7. 00   00700   OPERATION OF PLANT	0	1, 250, 958		1, 435, 563	925	7.00
8.00   00800   LAUNDRY & LI NEN SERVI CE 9.00   00900   HOUSEKEEPI NG	0	62, 158 27, 720		71, 331 43, 286	0 397	8. 00 9. 00
10. 00   01000   DI ETARY	0	37, 720 131, 148	19, 354	43, 200 150, 502	204	10.00
11. 00   01100   CAFETERI A		35, 830		41, 118	256	11. 00
13. 00 01300 NURSING ADMINISTRATION		66, 664	9, 838	76, 502	1, 468	1
14. 00 01400 CENTRAL SERVI CES & SUPPLY	l ol	129, 967	19, 179	149, 146	393	1
15. 00 01500 PHARMACY	o	28, 381	4, 188	32, 569	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	o	96, 317		110, 531	556	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	534, 822	78, 924	613, 746	2, 387	30. 00
31. 00 03100 INTENSIVE CARE UNIT	0	210, 785	31, 106	241, 891	1, 050	•
41. 00   04100   SUBPROVI DER -   RF	0	0	0	0	0	41.00
42. 00   04200   SUBPROVI DER	0	O FF 744	0	(2.070	0	42.00
43. 00 O4300 NURSERY  ANCI LLARY SERVI CE COST CENTERS	0	55, 744	8, 226	63, 970	461	43. 00
50. 00 05000 OPERATING ROOM	O	295, 692	43, 635	339, 327	1, 787	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		28, 326	4, 180	32, 506	83	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		205, 716	30, 358	236, 074	1, 343	1
57. 00   05700   CT   SCAN	l ol	7, 958	1, 174	9, 132	135	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	o	9, 721	1, 434	11, 155	78	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	88, 413	13, 047	101, 460	35	59. 00
60. 00   06000   LABORATORY	0	150, 099	22, 150	172, 249	1, 508	60.00
60. 01   06001   BL00D   LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	31, 542	4, 655	36, 197	303	65. 00
66. 00   06600   PHYSI CAL THERAPY	0	22, 657	3, 344	26, 001	1, 135	66. 00
68. 00 06800 SPEECH PATHOLOGY	0	3, 507	517	4, 024	47	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	166	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0	0	0	0	73. 00
76. 00 03950 CARDI AC REHAB		12, 919	1, 906	14, 825	116	1
OUTPATIENT SERVICE COST CENTERS	<u> </u>	12, 717	1,700	1 17 020	1,10	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	o	0	89. 00
91. 00   09100   EMERGENCY	0	192, 016	28, 336	220, 352	2, 015	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
OTHER REIMBURSABLE COST CENTERS		O	0	ol	0/0	101 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	U	868	101. 00
SPECIAL PURPOSE COST CENTERS  113.00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
116. 00 11600 HOSPI CE	o	0	0	0	306	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	l ol	4, 240, 689	625, 801	4, 866, 490		118. 00
NONREI MBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	.,				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18, 333	0	18, 333	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	658	192. 00
194. 00 07950 MCH	0	0	0	0		194. 00
194. 01 07951 RENTAL	0	0	51, 599	51, 599		194. 01
194. 02 07952 CMHS	0	0	0	0		194. 02
194. 03 07953 MCH	0	0	0	0		194. 03
194. 04 07954 WI C 194. 05 07955 0THER NONREIMBURSABLE COSTS	0	0	0	0		194. 04
	0	0	0	U O		194. 05
194. 06 07956 RHC- FOREST RIDGE 194. 07 07957 PHILLIPS HALL	0	0	0	0		194. 06 194. 07
194. 08 07958 OB DRS		0	0	0		194. 07
194. 09 07959 THE WATERS		445, 754	65, 780	511, 534		194. 09
194. 10 07960 CAMBRI DGE CI TY		,	0	0		194. 10
194.11 07961 WELL BEING		Ö		ol		194. 11
200.00 Cross Foot Adjustments				o		200. 00
201.00 Negative Cost Centers		0	0	o		201. 00
202.00   TOTAL (sum lines 118-201)	0	4, 704, 776	743, 180	5, 447, 956	28, 378	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 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 2/15/2017 2:11 pm

			''	12/01/2010	2/15/2017 2:1	1 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	•
	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7.00	8. 00	9. 00	10. 00	
GENERAL SERVI CE COST CENTERS	T	Г				
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00   00200   NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL	609, 885					5. 00
7. 00 00700 OPERATION OF PLANT	45, 989	1	1			7. 00
8. 00   00800   LAUNDRY & LINEN SERVICE	4, 027	37, 711				8. 00
9. 00   00900   HOUSEKEEPI NG	8, 885	1		80, 240		9. 00
10. 00   01000   DI ETARY	5, 249				238, 375	10.00
11. 00   01100   CAFETERI A	2, 945			537	0	11. 00
13.00 01300 NURSING ADMINISTRATION	25, 480			925	0	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	11, 376	1		925	0	14. 00
15. 00   01500   PHARMACY	29, 590	l	1	463	0	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	11, 708	58, 435	5 0	656	0	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1			10 701	100.001	
30. 00   03000   ADULTS & PEDI ATRI CS	44, 658		1		183, 001	30.00
31. 00 03100 I NTENSI VE CARE UNIT	19, 045	127, 883		3, 074	55, 374	31.00
41. 00   04100   SUBPROVI DER -   RF	0		0	0	0	41.00
42. 00   04200   SUBPROVI DER	0	00000	0	0	0	42.00
43. 00 04300 NURSERY	8, 104	33, 820	1, 904	269	0	43. 00
ANCILLARY SERVICE COST CENTERS	27 505	170.207	20, 201	7 010	0	FO 00
50. 00 05000 OPERATING ROOM	37, 595	l	1	7, 012	0	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM 54.00   05400   RADIOLOGY-DIAGNOSTIC	1, 677	17, 186			0	52.00
	27, 013	l		4, 610	0	54.00
57. 00 05700 CT SCAN	4, 524	4, 828	1	U	0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 956		1	0/5	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	9, 948	l			0	59.00
60. 00   06000   LABORATORY	42, 638	1	1	2, 074	0	60.00
60. 01 06001 BLOOD LABORATORY	0	10 127	_	1 721	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	5, 759	1	1	1, 731	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	19, 429	1		9, 474		66.00
68. 00 06800 SPEECH PATHOLOGY	773	2, 128	0	200	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 361			298	0	69. 00 71. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	11, 114			U	0	71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENT 73.00   07300   DRUGS CHARGED TO PATIENTS	44, 002			0	0	72.00
	-			0	0	
76. 00 03950 CARDI AC REHAB	2, 084		)	U	0	76. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0		0	0	0	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	ł		0	0	89. 00
91. 00   09100   EMERGENCY	40, 092	1	_	5, 162	0	91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	40, 092	110, 490	20, 207	3, 102	U	91.00
OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	15, 242	C	0	821	0	101. 00
SPECIAL PURPOSE COST CENTERS	15, 242		<u>,                                    </u>	021	0	101.00
113. 00 11300   INTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
116. 00 11600 HOSPI CE	9, 345	l c	0	o	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	494, 608	<b>l</b>		_		
NONREI MBURSABLE COST CENTERS	474,000	1, 471, 554	07,021	00, 014	230, 373	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	192	11, 123	8 0	194	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	16, 732		56			192. 00
194. 00 07950 MCH	0			0		194. 00
194. 01 07951 RENTAL	902		ol o	17, 695		194. 01
194. 02 07952 CMHS	0		ol o	17, 070		194. 02
194. 03 07953 MCH	0	7		0		194. 03
194. 04 07954 WI C	0	_	o o	0		194. 04
194. 05 07955 OTHER NONREI MBURSABLE COSTS	239		2, 389	0		194. 05
194. 06 07956 RHC- FOREST RIDGE	76, 537		701	0		194. 06
194. 07 07957 PHI LLI PS HALL	70,007		916	1, 537		194. 07
194. 08 07958 0B DRS	1 0		1, 514			194. 07
194. 09 07959 THE WATERS	10, 320		19, 672			194. 00
194. 10 07960 CAMBRI DGE CI TY	2, 631		17, 0/2	0		194. 09
194. 11 07961  WELL BEING	7, 724			0		194. 10
200.00 Cross Foot Adjustments	1,124		7	٩	U	200. 00
201.00 Negative Cost Centers	0	٠		Λ	Λ	200.00
202.00 TOTAL (sum lines 118-201)	609, 885		113, 069	80, 240		
(25	1 237,300	., ., ., ., ., ., ., ., ., ., ., ., ., .		20,210		

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0030

Peri od: Worksheet B From 01/01/2015 Part II To 12/31/2015 Date/Time Prepared:

2/15/2017 2:11 pm Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL RECORDS & SERVICES & ADMI NI STRATI ON SUPPLY LI BRARY 11. 00 13.00 15.00 14.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 66, 594 11.00 01300 NURSING ADMINISTRATION 4, 304 149, 124 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 242, 502 14.00 1,811 14 00 15.00 01500 PHARMACY C 400 80, 241 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 3, 183 185, 514 16.00 445 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 125 47,624 4, 362 0 25.862 30.00 03100 INTENSIVE CARE UNIT 0 31.00 4, 162 17,813 984 10, 731 31.00 04100 SUBPROVI DER - I RF 0 41.00 0 41.00 0 0 C 04200 SUBPROVI DER 0 42.00 Ω 0 Λ 42.00 43.00 04300 NURSERY 1,834 7,849 0 0 5, 867 43.00 ANCILLARY SERVICE COST CENTERS 27, 020 50.00 05000 OPERATING ROOM 36, 852 0 50.00 8, 610 12, 743 05200 DELIVERY ROOM & LABOR ROOM 52.00 329 1, 406 0 Λ 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 6,040 C 6, 177 0 20, 999 54.00 57.00 05700 CT SCAN 531 1,590 0 6, 562 57.00 58 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 368 Ω 3, 551 58 00 564 05900 CARDIAC CATHETERIZATION 59.00 123 C  $\cap$ 1,004 59.00 0 60.00 06000 LABORATORY 8, 230 30, 418 26, 789 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 0 0 0 06500 RESPIRATORY THERAPY 65.00 1.293 466 2,084 65.00 1, 191 66.00 06600 PHYSI CAL THERAPY 5, 108 2, 316 66.00 0 06800 SPEECH PATHOLOGY 68.00 142 77 68.00 69 00 06900 ELECTROCARDI OLOGY 620 Ω 697 2 393 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 35, 589 8,878 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 140, 909 0 8, 106 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 C 80, 241 0 73.00 03950 CARDI AC REHAB 597 2, 553 232 76.00 265 76.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 09100 EMERGENCY 35, 027 0 30, 573 91.00 8.184 4,641 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 1, 235 101. 00 667 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 391 1, 235 116.00 SUBTOTALS (SUM OF LINES 1-117) 66, 594 149, 124 242, 502 80<u>, 241</u> 185, 514 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 C 0 0 190. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192, 00 0 194. 00 07950 MCH 0 0 194, 00 194. 01 07951 RENTAL 0 0 0 194. 01 0000000000 0 194. 02 07952 CMHS 0 194. 02 0 0 0 194. 03 194. 03 07953 MCH Ω 0 194. 04 07954 WIC 0 0 0 0 194. 04 194. 05 07955 OTHER NONREI MBURSABLE COSTS 0 194. 05 194. 06 07956 RHC- FOREST RIDGE 0 194, 06 0 0 194. 07 07957 PHILLIPS HALL C 0 0 194. 07 194.08 07958 OB DRS 0 0 194. 08 194.09 07959 THE WATERS 0 0 0 194. 09 194. 10 07960 CAMBRIDGE CITY 0 n|194. 10 C 194. 11 07961 WELL BEING 0 0 0 0 194. 11 200. 00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118-201) 185, 514 202. 00 202.00 66, 594 149, 124 242, 502 80, 241

| Period: | Worksheet B | From 01/01/2015 | Part II | To | 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0030

				To 12/31/2015 Date/T	ime Prepared:
Cost Center Description	Subtotal	Intern &	Total		017 2:11 pm
p		Residents Cost			
		& Post			
		Stepdown Adjustments			
	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS					
1.00   00100   NEW CAP REL COSTS-BLDG & FIXT 2.00   00200   NEW CAP REL COSTS-MVBLE EQUIP					1.00
2.00   00200   NEW CAP REL COSTS-MVBLE EQUIP 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT		•			4.00
5. 00 00500 ADMINISTRATIVE & GENERAL		•			5. 00
7.00 00700 OPERATION OF PLANT					7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE					8.00
9. 00   00900  HOUSEKEEPI NG 10. 00   01000  DI ETARY					9. 00 10. 00
11. 00 01100 CAFETERI A					11.00
13.00 01300 NURSING ADMINISTRATION					13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY					15. 00 16. 00
I NPATIENT ROUTINE SERVICE COST CENTERS					10.00
30. 00 03000 ADULTS & PEDIATRICS	1, 299, 800	0	1, 299, 800		30.00
31. 00 03100 I NTENSI VE CARE UNI T	487, 140	0	487, 140		31. 00
41. 00   04100   SUBPROVI DER - I RF 42. 00   04200   SUBPROVI DER	0	0	(		41. 00
42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY	124, 078	0	124, 078		42. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	121,070	<u> </u>	121,070	<u> </u>	10.00
50.00   05000   OPERATING ROOM	670, 623	0	670, 623		50. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	54, 096	0	54, 096		52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 57. 00   05700   CT   SCAN	435, 271 27, 302	0	435, 27° 27, 30°		54. 00 57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	24, 570	o	24, 570		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	167, 343	О	167, 343		59. 00
60. 00   06000   LABORATORY	375, 114	0	375, 114		60.00
60. 01   06001   BLOOD LABORATORY 65. 00   06500   RESPI RATORY THERAPY	0 66, 970	0	66, 970		60. 01 65. 00
66. 00   06600   PHYSI CAL THERAPY	80, 884	o	80, 884		66.00
68.00 06800 SPEECH PATHOLOGY	7, 194	O	7, 194		68. 00
69. 00 06900 ELECTROCARDI OLOGY	7, 535	0	7, 535		69. 00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00   07200   MPL. DEV. CHARGED TO PATIENT	55, 581 193, 017	0	55, 581 193, 013		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATTENTS	80, 241	0	80, 24		73. 00
76. 00 03950 CARDI AC REHAB	20, 672	O	20, 672		76.00
OUTPATIENT SERVICE COST CENTERS		-1		-	
88.00   08800   RURAL HEALTH CLINIC 89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0 0	0		) )	88. 00 89. 00
91. 00   09100   EMERGENCY	482, 749	0	482, 749		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.2_,	0			92. 00
OTHER REIMBURSABLE COST CENTERS		_1		_	
101. 00 10100 HOME HEALTH AGENCY  SPECIAL PURPOSE COST CENTERS	18, 833	0	18, 833	3	101. 00
113. 00 11300   NTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
116. 00 11600 HOSPI CE	11, 277	0	11, 27		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	4, 690, 290	0	4, 690, 290	)	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	29, 842	0	29, 842	2	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	17, 446	0	17, 446		192. 00
194. 00 07950 MCH	0	0	(		194. 00
194. 01 07951 RENTAL 194. 02 07952 CMHS	70, 196	0	70, 196		194. 01 194. 02
194. 03 07953  MCH		0	(		194. 02
194. 04 07954 WI C	o	O	(		194. 04
194. 05 07955 OTHER NONREI MBURSABLE COSTS	2, 628	0	2, 628		194. 05
194. 06 07956 RHC- FOREST RIDGE 194. 07 07957 PHILLIPS HALL	81, 050	0	81, 050		194. 06 194. 07
194.08 07958 0B DRS	2, 453 1, 514	0	2, 453 1, 514		194. 07
194. 09 07959 THE WATERS	541, 740	Ö	541, 740		194. 09
194. 10 07960 CAMBRI DGE CITY	2, 704	0	2, 704	4	194. 10
194. 11 07961 WELL BEING	8, 093	0	8, 093		194. 11
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0	(	) )	200. 00 201. 00
202.00 TOTAL (sum lines 118-201)	5, 447, 956	0	5, 447, 956	5	202. 00
	,	,			•

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0030 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 2/15/2017 2:11 pm CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliation ADMINISTRATIVE FIXT **FOULP** BENEFITS & GENERAL (SQUARE (SQUARE (ACCUM. DEPARTMENT FEET) FEET) (GROSS COST) SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 258 937 00100 NEW CAP REL COSTS-BLDG & FIXT 1 00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 277, 172 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 361 1, 361 30, 945, 074 4.00 00500 ADMINISTRATIVE & GENERAL 28. 999 28, 999 5, 697, 658 58, 345, 286 5 00 -13, 863, 026 5 00 7.00 00700 OPERATION OF PLANT 68,849 68, 849 1,008,559 4, 399, 551 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 3, 421 3, 421 385, 264 8.00 0 9.00 00900 HOUSEKEEPI NG 2,076 2,076 433, 412 850, 014 9.00 01000 DI ETARY 10.00 222 992 7 218 7 218 502, 149 10 00 11.00 01100 CAFETERI A 1,972 1, 972 278, 726 0 281, 754 11.00 01300 NURSING ADMINISTRATION 1, 600, 795 0 2, 437, 563 13.00 3,669 3, 669 13.00 0 01400 CENTRAL SERVICES & SUPPLY 7, 153 1, 088, 261 14.00 7.153 428, 415 14.00 01500 PHARMACY 15.00 1.562 1, 562 C 2, 830, 772 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 5, 301 606, 467 1, 120, 056 16.00 5, 301 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDLATRICS 29, 435 29, 435 2, 603, 458 0 4, 272, 234 30.00 31.00 03100 INTENSIVE CARE UNIT 11, 601 11,601 1, 145, 512 0 1, 821, 966 31.00 41.00 04100 SUBPROVI DER - I RF 0 41.00 42.00 04200 SUBPROVI DER 0 0 0 42.00 04300 NURSERY 503, 036 775, 243 43.00 3,068 3,068 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 50.00 16, 274 16, 274 1, 948, 959 3, 596, 583 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1,559 1, 559 90, 442 0 160, 387 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 322 11, 322 1, 465, 027 2, 584, 282 54.00 57.00 05700 CT SCAN 438 438 147, 633 432, 810 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 535 535 85, 224 0 282, 820 58.00 59.00 05900 CARDIAC CATHETERIZATION 4,866 4.866 38, 300 951, 673 59.00 60.00 06000 LABORATORY 8, 261 8, 261 1, 644, 977 4, 079, 039 60.00 06001 BLOOD LABORATORY 60.01 0 0 0 60.01 65.00 06500 RESPIRATORY THERAPY 1,736 1,736 330, 949 550, 926 65.00 06600 PHYSI CAL THERAPY 1, 238, 130 1, 858, 705 66,00 1, 247 1, 247 66 00 68.00 06800 SPEECH PATHOLOGY 193 193 51, 539 73, 991 68.00 06900 ELECTROCARDI OLOGY 69.00 0 0 180, 485 0 321, 572 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 1, 063, 227 71.00 0 71.00 0 07200 I MPL. DEV. CHARGED TO PATIENT 0 0 4, 209, 494 72.00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 0 73.00 76.00 03950 CARDI AC REHAB 711 711 126, 925 199, 380 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 91.00 09100 EMERGENCY 10,568 10, 568 2, 197, 653 0 3, 835, 430 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 92 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 1, 458, 174 101. 00 946, 665 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 894, 048 116. 00 333, 729 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS -13, 863, 026 233, 395 233, 395 47, 317, 368 118. 00 118.00 25, 355, 667 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,009 18, 333 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 717, 668 0 0 C 1, 600, 690 192. 00 194. 00 07950 MCH 0 0 0 194 00 0 194. 01 07951 RENTAL 0 19, 244 0 0 86, 327 194. 01 194. 02 07952 CMHS 0 0 0 0 194. 02 C 0 0 194. 03 07953 MCH 0 194. 03 0 0 194. 04 07954 WIC 01194.04 O C 194.05 07955 OTHER NONREIMBURSABLE COSTS 0 0 0 0 22, 861 194. 05 0 194. 06 07956 RHC- FOREST RIDGE 0 7, 321, 799 194. 06 4, 156, 872 194. 07 07957 PHILLIPS HALL 0 0 194. 07 0 C 194.08 07958 OB DRS 0 Λ 0 194.08 194.09 07959 THE WATERS 987, 324 194. 09 24,533 24, 533 233, 347 194. 10 07960 CAMBRIDGE CITY 79, 365 251, 658 194. 10 194. 11 07961 WELL BEING 738, 926 194. 11 402, 155 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 8, 785, 270 13, 863, 026 202. 00 202.00 4, 704, 776 743, 180 Part I) 0. 237603 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 18. 169578 2.681295 0.283899

Health Financial Systems	ENRY COUNTY MEMO	ORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
				From 01/01/2015 To 12/31/2015		
	CAPITAL REL	ATED COSTS				
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1.00	2. 00	4. 00	5A	5. 00	
204.00 Cost to be allocated (per Wkst. B, Part II)			28, 37	8	609, 885	204. 00
205.00 Unit cost multiplier (Wkst. B, Part			0. 00091	7	0. 010453	205. 00

	FINANCIAL SYSTEMS		DESCRIPTION			Wardington CMS	
COST AL	LOCATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 01/01/2015 o 12/31/2015		pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	2/15/2017 2: 1 CAFETERI A (FTE' S)	ı pm
		7.00	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
2.00 (4.00 (5.00 (6.00 (	DO100 NEW CAP REL COSTS-BLDG & FIXT D0200 NEW CAP REL COSTS-MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D0500 ADMINISTRATIVE & GENERAL D0700 OPERATION OF PLANT D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS	134, 484 3, 421 2, 076 7, 218 1, 972 3, 669 7, 153 1, 562 5, 301	707, 035 29, 931 8, 039 0 0	5, 378 105 36 62 62 31	7, 499 0 0 0 0	28, 579 1, 847 777 0 1, 366	13. 00 14. 00 15. 00
	03000 ADULTS & PEDIATRICS	29, 435	142, 442	1, 326	5, 757	4, 775	30.00
31. 00 (0 41. 00 (0 42. 00 (0 43. 00 (0	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY	11, 601 0 0 3, 068	32, 100 0 0	206 0 0	1, 742 0 0	1, 786 0 0	31. 00 41. 00 42. 00
	ANCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM	16, 274	126, 819	470	0	3, 695	50.00
52. 00 (0 54. 00 (0 57. 00 (0 58. 00 (0	D5200 DELIVERY ROOM & LABOR ROOM D5400 RADIOLOGY-DIAGNOSTIC D5700 CT SCAN D5800 MAGNETIC RESONANCE IMAGING (MRI)	1, 559 11, 322 438 535	2, 140 51, 328 0 0	38 309 0 0	0 0 0	141 2, 592 228 158	52. 00 54. 00 57. 00 58. 00
	D5900 CARDI AC CATHETERI ZATI ON	4, 866				53	
	D6000 LABORATORY D6001 BLOOD LABORATORY	8, 261	l .	1		3, 532 0	1
1	06500 RESPI RATORY THERAPY	1, 736		116	_	555	
	06600 PHYSI CAL THERAPY	1, 247		1		2, 192	1
4	D6800 SPEECH PATHOLOGY D6900 ELECTROCARDI OLOGY	193	l	0 20	_	61 266	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		_	0		0	
	07200 IMPL. DEV. CHARGED TO PATIENT	C	0	0	0	0	
	D7300 DRUGS CHARGED TO PATIENTS	C		0	_	0	
	D3950 CARDIAC REHAB DUTPATIENT SERVICE COST CENTERS		<u> </u>	<u> </u>	0	256	76. 00
-	D8800 RURAL HEALTH CLINIC	C	0	0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1	0	_	0	
	D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 568	126, 355	346	0	3, 512	91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS						72.00
	10100 HOME HEALTH AGENCY	C	0	55	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS  11300 INTEREST EXPENSE		1				] 113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114. 00
	11600 HOSPI CE	C	0	0	0		116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	133, 475	549, 161	4, 076	7, 499	28, 579	118. 00
_	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 009		13	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	C	350	1	0		192. 00
	07950 MCH 07951 RENTAL	C	0	0 1, 186	0		194. 00 194. 01
	07952 CMHS		Ö	1, 100	0		194. 02
194. 03	07953 MCH	c	0	0	0		194. 03
	07954 WIC	C	0	0	0		194. 04
	D7955 OTHER NONREIMBURSABLE COSTS D7956 RHC- FOREST RIDGE		14, 936 4, 385	1	0		194. 05 194. 06
	07957 PHI LLI PS HALL	C	5, 728	l .	_		194. 07
	07958 OB DRS	C	9, 465	l .	0		194. 08
	D7959 THE WATERS D7960 CAMBRIDGE CITY	C	123, 010	0	0		194. 09 194. 10
	07960 CAMBRIDGE CITT				0		194. 10
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	F 444 000	/45 011	1 4/0 633	040.000	407 000	201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	5, 444, 898	615, 311	1, 162, 080	943, 383	436, 320	202.00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I Cost to be allocated (per Wkst. B, Part II)	) 40. 487329 1, 482, 477	1	1			203. 00 204. 00

Health Financial Systems	ENRY COUNTY MEN	In Lie	u of Form CMS-2	2552-10		
COST ALLOCATION - STATISTICAL BASIS			Period: Worksheet B-1			
				From 01/01/2015 To 12/31/2015	Date/Time Pre 2/15/2017 2:1	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(HOURS OF	(PATI ENT	(FTE'S)	
	(SQUARE	(POUNDS OF	SERVI CE)	DAYS)		
	FEET)	LAUNDRY)				
	7.00	8. 00	9. 00	10.00	11. 00	
205.00 Unit cost multiplier (Wkst. B, Part	11. 023445	0. 159920	14. 92004	5 31. 787572	2. 330173	205. 00
11)						

Health Financial Sy		HENRY COUNTY MEMO				u of Form CMS-2552-1
COST ALLOCATION - S	TATISTICAL BASIS		Provi der Co		eriod: rom 01/01/2015	Worksheet B-1
					o 12/31/2015	Date/Time Prepared
Cost Co	enter Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	2/15/2017 2:11 pm
0031 00	arter beserretton	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
			SUPPLY	REQUIS.)	LI BRARY	
		(DI RECT	(COSTED		(TIME	
		NRSI NG HRS) 13.00	REQUI S. ) 14. 00	15. 00	SPENT) 16.00	
GENERAL SERV	CE COST CENTERS	13.00	14.00	15.00	10.00	
	REL COSTS-BLDG & FIXT					1.0
	REL COSTS-MVBLE EQUIP					2.0
	E BENEFITS DEPARTMENT					4. C
l I	STRATIVE & GENERAL					5. C
	' & LINEN SERVICE					7. C 8. C
9. 00 00900 HOUSEKE						9. 0
10. 00 01000 DI ETARY						10.0
11. 00 01100 CAFETER						11. C
	ADMINISTRATION	14, 952	7 044 404			13. 0
14. 00   01400   CENTRAL 15. 00   01500   PHARMAC	. SERVICES & SUPPLY	0	7, 244, 606 11, 948			14. C 15. C
	. RECORDS & LI BRARY		13, 302			16. 0
	JTI NE SERVI CE COST CENTERS		10,002		27 .00	1010
30. 00 03000 ADULTS	& PEDI ATRI CS	4, 775	130, 309	0	335	30. C
31. 00   03100   I NTENSI		1, 786	29, 402			31. C
41. 00   04100   SUBPROV		0	0	0	_	41. 0
42. 00   04200   SUBPROV 43. 00   04300   NURSERV		0 787	0	0	_	42. C 43. C
	RVICE COST CENTERS	767	0	0	70	43.0
50. 00 05000 OPERATI		3, 695	380, 702	0	350	50. C
	Y ROOM & LABOR ROOM	141	0	0		52. C
	GY-DI AGNOSTI C	0	184, 536			54. C
57. 00   05700 CT SCAN		0	47, 500	0		57. C
	C RESONANCE IMAGING (MRI) CATHETERIZATION	0	16, 841	0	46 13	58. C 59. C
60. 00 06000 LABORAT		o o	908, 746	1	347	60. 0
60. 01 06001 BL00D I		0	0	0	o	60. C
	TORY THERAPY	0	13, 935			65. C
66. 00   06600   PHYSI CA		0	35, 574			66. C
68. 00   06800 SPEECH 69. 00   06900 ELECTRO		0	87 20, 823	0	31	68. C
	. SUPPLIES CHARGED TO PATIENTS	0	1, 063, 227		115	71. 0
	EV. CHARGED TO PATIENT	o	4, 209, 494	Ö	105	72. 0
	HARGED TO PATIENTS	0	0	100	o	73. C
76. 00 03950 CARDI A		256	7, 909	0	3	76. C
88. 00 08800 RURAL F	ERVICE COST CENTERS	0	0	0	O	88. 0
	LY QUALIFIED HEALTH CENTER	0	0			89.0
91. 00 09100 EMERGEN		3, 512	138, 658		-	91. 0
	TION BEDS (NON-DISTINCT PART)					92. 0
	RSABLE COST CENTERS					
101. 00 10100 HOME HE		0	19, 931	0	16	101. C
113. 00 11300 I NTERES	OSE COST CENTERS					113. 0
114. 00 11400 UTI LI ZA						114. 0
116.00 11600 HOSPI CE		0	11, 682	0	16	116. C
	LS (SUM OF LINES 1-117)	14, 952	7, 244, 606	100	2, 403	118. C
	BLE COST CENTERS					100.0
	LOWER, COFFEE SHOP & CANTEEN ANS' PRIVATE OFFICES	0	0	0	_	190. C 192. C
194. 00 07950 MCH	ANS TRIVATE OFFICES		0	0	_	194. C
194. 01 07951 RENTAL		o	0	Ō	o	194. C
194.02 07952 CMHS		0	0	0	o	194. C
194. 03 07953 MCH		0	0	0	0	194. C
194. 04 07954 WI C	IONIDEL MINIDEARLE COSTS	0	0	0	0	194. 0
194. 06 07956 RHC- FO	IONREIMBURSABLE COSTS		0			194. C 194. C
194. 07 07957 PHI LLI F		o o	0	Ö	l ő	194. 0
194.08 07958 OB DRS			0	O	o	194. C
194. 09 07959 THE WAT		0	0	0	0	194. C
194. 10 07960 CAMBRI [		0	0	0	0	194. 1
194. 11 07961 WELL BE 200. 00 Cross F	ING oot Adjustments		0	1		194. 1 200. 0
	ve Cost Centers					201. 0
	be allocated (per Wkst. B,	3, 206, 878	1, 661, 701	3, 576, 052	1, 634, 222	202. 0
Part I)	<del></del>					
	st multiplier (Wkst. B, Part I)	1 1		35, 760. 520000		203. 0
	be allocated (per Wkst. B,	149, 124	242, 502	80, 241	185, 514	204. C
204.00 Cost to		,	/			

Health Financial Systems HE		In Lieu of Form CMS-2552-10					
COST ALLOCATION - STATISTICAL BASIS				Peri od:			
				From 01/01/2015 To 12/31/2015	Date/Time Pre 2/15/2017 2:1		
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL			
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &			
		SUPPLY	REQUI S. )	LI BRARY			
	(DI RECT	(COSTED		(TIME			
	NRSING HRS)	REQUIS.)		SPENT)			
	13.00	14.00	15. 00	16.00			
205.00 Unit cost multiplier (Wkst. B, Part II)	9. 973515	0. 033473	802. 41000	0 77. 200999		205. 00	

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

From 01/01/2015 Part I 12/31/2015 Date/Time Prepared: 2/15/2017 2:11 pm Title XVIII Hospi tal PPS Costs Therapy Limit Cost Center Description Total Cost Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 4. 00 1.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 8, 968, 547 8.968.547 8.968.547 03100 INTENSIVE CARE UNIT 3, 527, 760 3, 527, 760 0 3, 527, 760 31.00 31.00 04100 SUBPROVIDER - IRF 0 41.00 0 41.00 04200 SUBPROVI DER 42.00 0 42.00 0 0 0 04300 NURSERY 43.00 1, 330, 404 1, 330, 404 1, 330, 404 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6, 496, 216 6, 496, 216 6, 496, 216 50.00 05200 DELIVERY ROOM & LABOR ROOM 304, 082 0 304, 082 52.00 304, 082 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 035, 031 4, 035, 031 0 4, 035, 031 54.00 57.00 05700 CT SCAN 625, 562 625, 562 0 625, 562 57.00 o 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 409, 238 409, 238 409, 238 58.00 05900 CARDIAC CATHETERIZATION 1, 398, 444 1, 398, 444 59.00 1, 398, 444 0 59.00 60.00 06000 LABORATORY 5, 911, 858 5, 911, 858 4, 917 5, 916, 775 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 06500 RESPIRATORY THERAPY 807.210 807, 210 0 807, 210 65 00 65 00 06600 PHYSI CAL THERAPY 66.00 2, 563, 585 2, 563, 585 0 2, 563, 585 66.00 68.00 06800 SPEECH PATHOLOGY 101, 016 101, 016 101, 016 68.00 0 69.00 06900 ELECTROCARDI OLOGY 432, 219 432, 219 432, 219 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 637, 935 1, 637, 935 1, 637, 935 71 00 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 6, 246, 624 6, 246, 624 6, 246, 624 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 3, 576, 052 3, 576, 052 3, 576, 052 73.00 76 00 03950 CARDI AC REHAB 309, 421 309, 421 309, 421 76 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 o 89.00 0 6, 467, 317 91 00 09100 EMERGENCY 6, 467, 317 6, 467, 317 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 2, 110, 551 2, 110, 551 2, 110, 551 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 1, 831, 978 1, 831, 978 1, 831, 978 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 1.120.037 1, 120, 037 1, 120, 037 116. 00 60, 216, 004 200. 00 4, 917 200.00 Subtotal (see instructions) 60, 211, 087 0 60, 211, 087 201.00 Less Observation Beds 2, 110, 551 2, 110, 551 2, 110, 551 201. 00 202.00 Total (see instructions) 58, 100, 536 58, 100, 536 4.917 58, 105, 453 202. 00

Health Financial Systems	HENRY COUNTY MEM	ORIAL HOSPITAL		In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 2/15/2017 2:1	
			e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col . 7)	Ratio	Inpati ent	
	/ 00	7.00	0.00	0.00	Ratio	
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7. 00	8. 00	9. 00	10. 00	
30. 00 03000 ADULTS & PEDIATRICS	8, 368, 617		8, 368, 61	7		30.00
31. 00   03100   NTENSI VE CARE UNIT	4, 472, 272		4, 472, 27			31. 00
41. 00   04100   SUBPROVI DER -   I RF	4,472,272		4,412,21	2		41.00
42. 00   04200   SUBPROVI DER	0			0		42.00
43. 00   04300   NURSERY	770, 846		770, 84	6		43.00
ANCI LLARY SERVI CE COST CENTERS	770,040		770,04	<u> </u>		45.00
50. 00   05000   OPERATING ROOM	6, 454, 318	16, 786, 162	23, 240, 48	0. 279522	0. 000000	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	806, 193	683, 598			0. 000000	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 432, 675	13, 760, 104			0. 000000	54.00
57. 00   05700 CT SCAN	2, 391, 436	19, 338, 906			0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	142, 850	5, 781, 767			0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	201, 288	1, 529, 095	1, 730, 38	0. 808170	0.000000	59.00
60. 00   06000   LABORATORY	3, 839, 463	18, 515, 685	22, 355, 14	0. 264452	0.000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0. 000000	0.000000	60. 01
65. 00 06500 RESPIRATORY THERAPY	1, 923, 744	1, 533, 454	3, 457, 19	0. 233487	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	621, 105	3, 285, 168	3, 906, 27	0. 656274	0.000000	66.00
68. 00 06800 SPEECH PATHOLOGY	21, 166	94, 577	115, 74	0. 872761	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	872, 910	3, 060, 223	3, 933, 13	0. 109892	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	S 5, 850, 277	8, 888, 426	14, 738, 70	0. 111132	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	10, 453, 744	3, 058, 730	13, 512, 47	0. 462286	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	13, 020, 926	8, 467, 232	21, 488, 15	0. 166420	0.000000	73. 00
76. 00 03950 CARDI AC REHAB	813	392, 671	393, 48	4 0. 786362	0.000000	76. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	)	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89. 00
91. 00   09100   EMERGENCY	1, 257, 629	13, 191, 264			0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	) 475, 931	1, 319, 873	1, 795, 80	4 1. 175268	0. 000000	92.00

63, 378, 203

63, 378, 203

0

2, 080, 149

2, 090, 475 123, 857, 559

123, 857, 559

2, 080, 149

2, 090, 475 187, 235, 762

187, 235, 762

101. 00

113. 00

114. 00

116. 00 200. 00

201. 00

202. 00

116. 00 11600 HOSPI CE

101. 00 10100 HOME HEALTH AGENCY
SPECIAL PURPOSE COST CENTERS

114.00 11400 UTI LI ZATI ON REVIEW-SNF

113. 00 11300 | INTEREST EXPENSE

200.00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

			To 12/31/2015	Date/Time Prepared: 2/15/2017 2:11 pm	1:
-		Title XVIII	Hospi tal	PPS	—
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTE	RS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.0	
31.00 03100 NTENSIVE CARE UNIT				31.0	
41. 00   04100   SUBPROVI DER - I RF				41. 0	
42. 00   04200   SUBPROVI DER				42. 0	
43. 00 04300 NURSERY				43. 0	00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATI NG ROOM	0. 279522			50. 0	
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0. 204111			52. 0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 265589			54. 0	
57. 00   05700   CT SCAN	0. 028787			57. 0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MR				58. 0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 808170			59. 0	
60. 00   06000   LABORATORY	0. 264672			60. 0	
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 0	
65. 00 06500 RESPI RATORY THERAPY	0. 233487			65. 0	
66. 00   06600   PHYSI CAL THERAPY	0. 656274			66. 0	
68. 00 06800 SPEECH PATHOLOGY	0. 872761			68. 0	
69. 00 06900 ELECTROCARDI OLOGY	0. 109892			69. 0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PA				71. 0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 462286			72. 0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 166420			73. 0	
76. 00 03950 CARDI AC REHAB	0. 786362			76. 0	50
OUTPATIENT SERVICE COST CENTERS					00
88. 00 08800 RURAL HEALTH CLINIC	TED			88. 0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CEN				89. 0	
91. 00   09100   EMERGENCY	0. 447599			91. 0	
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	PART) 1. 175268			92. 0	JU
101. 00 10100 HOME HEALTH AGENCY				101. 0	00
SPECIAL PURPOSE COST CENTERS				101.0	JU
113.00 11300 INTEREST EXPENSE				113. 0	00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114. 0	
116. 00 11400 011E1ZATTON REVIEW-SNF				114. 0	
200.00 Subtotal (see instructions)				200. 0	
201.00 Less Observation Beds				200. 0	
202.00 Total (see instructions)				201. 0	
202.00   Total (See Histiactions)	Į l			J202. U	JU

COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provi der CC	CN: 15-0030	Peri od: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 2/15/2017 2:1	pared: 1 pm
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description		Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	8, 968, 547		8, 968, 54	17 0	8, 968, 547	30.00
31. 00   03100	INTENSIVE CARE UNIT	3, 527, 760		3, 527, 70	50 0	3, 527, 760	31.00
41. 00 04100	SUBPROVIDER - IRF	0			0 0	0	41.00
42.00 04200	SUBPROVI DER	0			0 0	0	42.00
43.00 04300	NURSERY	1, 330, 404		1, 330, 40	04	1, 330, 404	43.00
ANCI LL	ARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6, 496, 216		6, 496, 2	16 0	6, 496, 216	50. 00
52. 00 05200	DELIVERY ROOM & LABOR ROOM	304, 082		304, 08	32 0	304, 082	52.00
54. 00 05400	RADI OLOGY-DI AGNOSTI C	4, 035, 031		4, 035, 03	31 0	4, 035, 031	54.00
	CT SCAN	625, 562		625, 50		625, 562	57.00
	MAGNETIC RESONANCE IMAGING (MRI)	409, 238		409, 23		409, 238	
	CARDI AC CATHETERI ZATI ON	1, 398, 444		1, 398, 44		1, 398, 444	•
	LABORATORY	5, 911, 858		5, 911, 85		5, 916, 775	
	BLOOD LABORATORY	0		0,,,	0 0	0,7.0,770	60. 01
	RESPI RATORY THERAPY	807, 210	0	807, 2 <sup>-</sup>	0	807, 210	
	PHYSI CAL THERAPY	2, 563, 585	0	2, 563, 58		2, 563, 585	•
	SPEECH PATHOLOGY	101, 016	0	101, 0		101, 016	1
	ELECTROCARDI OLOGY	432, 219	Ü	432, 2		432, 219	1
	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 637, 935		1, 637, 93		1, 637, 935	•
	IMPL. DEV. CHARGED TO PATIENT	6, 246, 624		6, 246, 62		6, 246, 624	•
	DRUGS CHARGED TO PATIENTS	3, 576, 052		3, 576, 0		3, 576, 052	73.00
	CARDI AC REHAB	309, 421		3, 376, 03		309, 421	
	TIENT SERVICE COST CENTERS	307, 421		307, 42	21  0	307, 421	70.00
	RURAL HEALTH CLINIC	0			0 0	0	88. 00
	FEDERALLY QUALIFIED HEALTH CENTER					0	89. 00
	EMERGENCY	6, 467, 317		6, 467, 3°	17 0	6, 467, 317	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	2, 110, 551		2, 110, 5!		2, 110, 551	
	REIMBURSABLE COST CENTERS	2, 110, 331		2, 110, 3	)	2, 110, 551	92.00
	HOME HEALTH AGENCY	1, 831, 978		1, 831, 9	70	1, 831, 978	101 00
	AL PURPOSE COST CENTERS	1,031,970		1,031,9	' O	1, 031, 970	1101.00
	INTEREST EXPENSE						1 113. 00
	UTILIZATION REVIEW-SNF						114. 00
116. 00 11600		1 120 027		1 120 0	7	1, 120, 037	
		1, 120, 037	0	1, 120, 03			
	Subtotal (see instructions)	60, 211, 087	0	00/2::/0		60, 216, 004	
	Less Observation Beds	2, 110, 551	_	2, 110, 5		2, 110, 551	
202. 00	Total (see instructions)	58, 100, 536	0	58, 100, 53	36 4, 917	58, 105, 453	J2U2. UU

	ATION OF RATIO OF COSTS TO CHARGES	- MCT GOOM T MEM	Provi der C	CN: 15-0030	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 2/15/2017 2:1	pared:
				e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	8, 368, 617		8, 368, 61			30. 00
31. 00		4, 472, 272		4, 472, 27	2		31. 00
	04100 SUBPROVI DER - I RF	0			0		41. 00
42. 00	04200 SUBPROVI DER	0			0		42. 00
43. 00	04300 NURSERY	770, 846		770, 84	-6		43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00		6, 454, 318					1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	806, 193	· ·			0. 000000	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 432, 675	13, 760, 104			0. 000000	1
	05700 CT SCAN	2, 391, 436	19, 338, 906			0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	142, 850	5, 781, 767			0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	201, 288	1, 529, 095			0. 000000	1
60.00	06000 LABORATORY	3, 839, 463	18, 515, 685			0. 000000	
60. 01	06001 BLOOD LABORATORY	0	0	1	0. 000000	0. 000000	1
65. 00	06500 RESPI RATORY THERAPY	1, 923, 744	1, 533, 454			0. 000000	1
66. 00	06600 PHYSI CAL THERAPY	621, 105	3, 285, 168			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	21, 166	94, 577			0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	872, 910	3, 060, 223			0. 000000	
71. 00		5, 850, 277	8, 888, 426			0. 000000	1
72. 00		10, 453, 744					1
73. 00	07300 DRUGS CHARGED TO PATIENTS	13, 020, 926				0. 000000	
76. 00	03950 CARDI AC REHAB	813	392, 671	393, 48	0. 786362	0. 000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0		0. 000000		
89. 00		0	0		0.000000		
	09100 EMERGENCY	1, 257, 629				0. 000000	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	475, 931	1, 319, 873	1, 795, 80	1. 175268	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS	1		1			
101.00	10100 HOME HEALTH AGENCY	0	2, 080, 149	2, 080, 14	.9		101. 00
	SPECIAL PURPOSE COST CENTERS			ı			
	11300 I NTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF	_			_[		114. 00
	11600 HOSPI CE	0	,				116. 00
200.00		63, 378, 203	123, 857, 559	187, 235, 76	2		200. 00
201.00		(0.070.000	400 057 550	407.005.7			201. 00
202.00	Total (see instructions)	63, 378, 203	123, 857, 559	187, 235, 76	2		202. 00

			To 12/31/2015	Date/lime Pre   2/15/2017 2:1	
		Title XIX	Hospi tal	Cost	<u> </u>
Cost Center Description	PPS Inpatient		<u> </u>		
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS					30. 00
31.00 03100 INTENSIVE CARE UNIT					31. 00
41. 00   04100   SUBPROVI DER -   RF					41. 00
42. 00   04200   SUBPROVI DER					42. 00
43. 00   04300   NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					4
50. 00   05000   OPERATI NG 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 I MAGING (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 RESPI RATORY THERAPY	0. 000000				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66. 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 I MPL. 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					4
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. 00
91. 00   09100   EMERGENCY	0. 000000				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 000000				92. 00
OTHER REIMBURSABLE COST CENTERS					101 00
101. 00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS					112 00
113. 00 11300 INTEREST EXPENSE					113.00
114. 00 11400 UTI LI ZATI ON REVI EW-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 MEN	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2015 To 12/31/2015	Worksheet D Part I Date/Time Prep 2/15/2017 2:1	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 ADULTS & PEDI ATRI CS	1, 299, 800		1, 299, 80	· ·	183. 82	
31.00 INTENSIVE CARE UNIT	487, 140		487, 14	0 1, 742	279. 64	
41. 00 SUBPROVI DER - I RF	0	0		0	0. 00	
42. 00 SUBPROVI DER	0	0		0	0. 00	
43. 00 NURSERY	124, 078		124, 07		152. 81	43. 00
200.00 Total (lines 30-199)	1, 911, 018		1, 911, 01	9, 625		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 ADULTS & PEDIATRICS	2, 905					30. 00
31. 00   INTENSIVE CARE UNIT	988	276, 284				31.00
41. 00 SUBPROVI DER - I RF	0	0				41. 00
42. 00 SUBPROVI DER	0	0				42.00
43. 00 NURSERY	0	0				43. 00
200.00 Total (lines 30-199)	3, 893	810, 281				200. 00

Health Financial Systems HI	ENRY COUNTY MEN	MORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider Co		Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Pre 2/15/2017 2:1	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	· ·		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS				0.500.475	7.070	
50. 00   05000   OPERATI NG ROOM	670, 623					
52.00   05200   DELIVERY ROOM & LABOR ROOM	54, 096					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	435, 271				·	54.00
57. 00   05700   CT SCAN	27, 302				1, 842	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	24, 570				377	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	167, 343					59. 00
60. 00   06000   LABORATORY	375, 114				33, 855	
60. 01   06001   BLOOD LABORATORY	0	_	0.00000		0	60. 01
65. 00 06500 RESPIRATORY THERAPY	66, 970					
66. 00   06600   PHYSI CAL THERAPY	80, 884				·	
68. 00 06800 SPEECH PATHOLOGY	7, 194				938	
69. 00 06900 ELECTROCARDI OLOGY	7, 535					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	55, 581					
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	193, 017				74, 367	
73.00 07300 DRUGS CHARGED TO PATIENTS	80, 241				28, 526	
76. 00 03950 CARDI AC REHAB	20, 672	393, 484	0. 05253	6 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS				_		
88. 00 08800 RURAL HEALTH CLINIC	0	0	0. 00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000		0	89. 00
91. 00   09100   EMERGENCY	482, 749				16, 906	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	305, 880				·	
200.00   Total (lines 50-199)	3, 055, 042	169, 453, 403		25, 309, 813	340, 331	200. 00

Health Financial Systems HE	ENRY COUNTY MEM	ORIAL HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	rs Provider Co		Period: From 01/01/2015 To 12/31/2015		
		Title	XVIII	Hospi tal	PPS	ГРШ
Cost Center Description	Nursing School	Allied Health Cost		Swing-Bed Adjustment t Amount (see	Total Costs (sum of cols. 1 through 3,	
	1.00	2. 00	3. 00	instructions) 4.00	minus col. 4) 5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT	0	0		0 0	0	30. 00 31. 00
41. 00   04100   SUBPROVI DER -   I RF	0	0		0	0	41. 00
42. 00   04200  SUBPROVI DER 43. 00   04300  NURSERY	0	0		0	0	42. 00 43. 00
200.00 Total (lines 30-199)	0	0		0		200.00
Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Pass-Through		
				Cost (col. 7 x		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   I NTENSI VE CARE UNI T 41. 00   04100   SUBPROVI DER - I RF 42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY	7, 071 1, 742 0 0 812	0. 00 0. 00	98			30. 00 31. 00 41. 00 42. 00 43. 00
200.00 Total (lines 30-199)	9, 625		3, 89	3 0		200. 00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-0030	
THROUGH COSTS		From 01/01/2015   Part IV

				1	o 12/31/2015	Date/Time Pre 2/15/2017 2:1	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician Nu	ursing School	Allied Health		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	0	0	(	0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54.00
	05700 CT SCAN	0	0	(	0	0	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	(	0	0	59.00
	06000 LABORATORY	0	0	(	0	0	60.00
	06001 BLOOD LABORATORY	0	0	(	0	0	60. 01
	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0			0	66.00
	06800 SPEECH PATHOLOGY	0	0			0	68. 00
	06900 ELECTROCARDI OLOGY	0	0			0	69.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0			0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0			0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0			0	73.00
76. 00	03950   CARDI AC REHAB   OUTPATI ENT SERVI CE COST CENTERS	l d	0		)  0	0	76. 00
88. 00	08800 RURAL HEALTH CLINIC				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0			0	89.00
	09100 EMERGENCY		0			0	91.00
			0			0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			0	
200.00	Total (lines 50-199)	ı U	U	l (	η U	1	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	Provider CCN: 15-0030	From 01/01/2015	Worksheet D Part IV Date/Time Prepared: 2/15/2017 2:11 pm

				Т	o 12/31/2015	Date/Time Prep 2/15/2017 2:1	
			Title	: XVIII	Hospi tal	PPS	ГРШ
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
	·	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 + col.	to Charges	Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	_					
	05000 OPERATI NG ROOM	0	23, 240, 480	•			
	05200 DELIVERY ROOM & LABOR ROOM	0	1, 489, 791	•			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	15, 192, 779	•			54.00
	05700 CT SCAN	0	21, 730, 342				
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	5, 924, 617				58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	1, 730, 383				
	06000 LABORATORY	0	22, 355, 148				
	06001 BLOOD LABORATORY	0	0	0.000000			60. 01
65. 00	06500 RESPI RATORY THERAPY	0	3, 457, 198				65. 00
	06600 PHYSI CAL THERAPY	0	3, 906, 273				
	06800 SPEECH PATHOLOGY	0	115, 743				68. 00
	06900 ELECTROCARDI OLOGY	0	3, 933, 133				
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14, 738, 703	0.000000	0. 000000	2, 578, 922	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	13, 512, 474	0.000000	0.000000	5, 206, 327	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	21, 488, 158	0.000000	0.000000	7, 639, 632	73.00
76. 00	03950 CARDI AC REHAB	0	393, 484	0.000000	0.000000	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89. 00
91.00	09100 EMERGENCY	0	14, 448, 893	0.000000	0. 000000	506, 001	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 795, 804	0.000000	0. 000000	230, 123	92.00
200.00	Total (lines 50-199)	0	169, 453, 403			25, 309, 813	200. 00

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0030	Peri od: From 01/01/2015	Worksheet D
THROUGH COSTS				Date/Time Prepared

			''	0 12/31/2015	2/15/2017 2:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12. 00	13. 00			
ANCILLARY SERVICE COST CENTERS				ı		
50.00   05000   OPERATING ROOM	0	4, 309, 418	0			50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0			52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	4, 667, 771	0			54.00
57. 00  05700 CT SCAN	0	6, 060, 716				57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	1, 656, 034				58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	556, 386				59. 00
60. 00  06000  LABORATORY	0	2, 055, 800	0			60.00
60. 01  06001 BL00D LABORATORY	0	0	0			60. 01
65. 00   06500   RESPI RATORY THERAPY	0	226, 721	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	756	0			66. 00
68. 00   06800   SPEECH PATHOLOGY	0	0	0			68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	1, 797, 231	0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 930, 485	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	871, 308	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 427, 682	0			73. 00
76. 00 03950 CARDI AC REHAB	0	200, 167	0			76. 00
OUTPATIENT SERVICE COST CENTERS						
88.00   08800   RURAL HEALTH CLINIC	0	0	0			88. 00
89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89. 00
91. 00   09100   EMERGENCY	0	3, 682, 170	0			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	638, 114	0			92. 00
200.00 Total (lines 50-199)	0	32, 080, 759	0			200. 00

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0030	Peri od:	Worksheet D

Health Financial Systems HI	ENRY COUNTY MEN	IORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 2/15/2017 2:1	
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
	1.00	0.00	(see inst.)	(see inst.)		
ANOLILIADY OFFICE COOT OFFITEDO	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.070500	4 000 440			4 004 577	
50. 00 05000 OPERATING ROOM	0. 279522			0	1, 204, 577	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 204111			0	0	
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0. 265589			0	1, 239, 709	
57. 00   05700   CT   SCAN	0. 028787			0	174, 470	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 069074			0	114, 389	1
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 808170			0	449, 654	
60. 00   06000   LABORATORY	0. 264452	,		0	543, 660	
60. 01   06001   BLOOD   LABORATORY	0. 000000			0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 233487			0	52, 936	
66. 00   06600   PHYSI CAL THERAPY	0. 656274	756		0	496	
68. 00 06800 SPEECH PATHOLOGY	0. 872761	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 109892			0 0	197, 501	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 111132			0 0	214, 539	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 462286			0 0	402, 793	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 166420			0 27, 376		
76. 00 03950 CARDI AC REHAB	0. 786362	200, 167		0 0	157, 404	76. 00
OUTPATIENT SERVICE COST CENTERS		T	Т	T		
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
91. 00   09100   EMERGENCY	0. 447599			0 0	1, 648, 136	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 175268			0 0	749, 955	
200.00 Subtotal (see instructions)		32, 080, 759		0 27, 376		
201.00 Less PBP Clinic Lab. Services-Program				0 0	I	201. 00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)		32, 080, 759		0 27, 376	7, 720, 654	202. 00

				To 12/31/2015	Date/Time Pre 2/15/2017 2:1	
		Title	XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				
50. 00 05000 OPERATING ROOM	1	1				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0				52.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C						54.00
57. 00   05700 CT SCAN		0				57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00   06000   LABORATORY	0	0				60.00
60. 01   06001   BLOOD   LABORATORY	0	0				60. 01
65. 00 06500 RESPIRATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4, 556				73. 00
76. 00 03950 CARDI AC REHAB	0	0				76. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
91. 00   09100   EMERGENCY	0	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92. 00
200.00 Subtotal (see instructions)	0	4, 556				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges  202.00   Net Charges (line 200 +/- line 201)		A EE4				202 00
202.00   Net Charges (line 200 +/- line 201)	0	4, 556	1			202. 00

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0030	Peri od:	Worksheet D-1	
			From 01/01/2015	D-+- /T: D	
			To 12/31/2015	Date/Time Prep 2/15/2017 2:1	
·		Title XVIII	Hospi tal	PPS	<u>г рііі</u>
Cost Center Description			110001 141		
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room day	ys and swing-bed days	s, excluding newborn)		7, 071	1.00

DART 1 - ALL PROVIDER COMPORENTS   1.00		Title XVIII   Hospital	PPS	
IRRATITION   INTERPRETATION   PART   1 - ALL PROVIDER COMPONENTS		Cost Center Description	1 00	
INPATIENT MAYS		PART I - ALL PROVIDER COMPONENTS	1.00	
Impattent days (including private room days, and saing-bed days, excluding newborn)				
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do   3.00 do not complete this line.   5,407   4.00 do not complete this line.   5,407   4.00   5.00   Intain swing-bed SMF type Inpatient days (including private room days) through December 31 of the cost reporting period (if calendary year, enter 0 on this line)   7.00   Total swing-bed SMF type Inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line)   7.00   Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line)   7.00   Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line)   7.00   Total swing-bed MF type inpatient days applicable to the Program (excluding saling-bed and nextorm days)   7.00   Total swing-bed MF type inpatient days applicable to the Program (excluding saling-bed and nextorm days)   7.00   Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after   7.00   Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)   7.00   Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)   7.00   Total swing-bed SMF type inpatient days applicable to swing-bed SMF type inpatient days (including swing-bed days)   7.00   Total swing-bed SMF type inpatient days swing-bed SMF type inpatient days swing-bed SMF type i	1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7, 071	1.00
do not complete this line.  4. OS Semi-polivate room days (excluding swing-bed and observation bed days)  5. OS Intail swing-bed SW type Inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line)  7. OT Total swing-bed SW type Inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line)  7. OT Total swing-bed SW type Inpatient days (including private room days) through December 31 of the cost reporting period (if calendary year, enter 0 on this line)  8. OD Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line)  9. OD Total Inpatient days including private room days after December 31 of the cost reporting period (if calendary year, enter 0 on this line)  10. OS sing-bed SW type inpatient days applicable to the Program (excluding swing-bed and needs on days) including private room days after on through December 31 of the cost reporting period (if calendary year, enter 0 on this line)  10. OS sing-bed SW type inpatient days applicable to title xWIII only (including private room days) after through December 31 of the cost reporting period (if calendary year, enter 0 on this line)  10. OS sing-bed SW type inpatient days applicable to title xWIII only (including private room days)  11. OS Swing-bed SW type inpatient days applicable to title xW or XX only (including private room days)  12. OS Swing-bed SW type inpatient days applicable to title xW or XX only (including private room days)  13. OS Swing-bed SW type inpatient days applicable to title xW or XX only (including private room days)  14. OS Swing-bed SW type inpatient days applicable to services through December 31 of the cost reporting period (if calendary year, enter 0 on this line)  15. OT Total runsery days (title xW or XX only)  16. ON Swing-bed SW type inpatient provides applicable to services through Decem	2.00			
Semi-perivate room days (excluding swing-bed and observation bed days) Tool Total swing-bed SRF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed SRF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room period period reporting period (including private room period period reporting period (includi	3. 00		0	3. 00
reporting beriod  6. 00 Total swing-hed SNF type inpatient days (including private rose days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 01 Total swing-hed NF type inpatient days (including private rose days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 02 Total inpatient days including private rose days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 09 Total inpatient days including private rose days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed SNF type inpatient days applicable to this line)  10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed SNF type inpatient days applicable to title SVIII only (including private rose days) after through December 31 of the cost reporting period (see instructions)  10. 00 Swing-bed SNF type inpatient days applicable to title SVIII only (including private rose days) after through December 31 of the cost reporting period (see instructions)  10. 00 Swing-bed SNF type inpatient days applicable to titles Vor XIX only (including private rose days)  10. 00 Swing-bed SNF type inpatient days applicable to titles Vor XIX only (including private rose days)  10. 00 Swing-bed SNF type inpatient days applicable to titles Vor XIX only (including private rose days)  10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days)  10. 01 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days)  10. 01 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost reporting period (including private rose days)  10. 01 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost reporting period (line SNF type services applicable to services after December 31 of the cost reporting period (line SNF type services after December 31 of t	4.00		5, 407	4.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   7.00   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)   8.00   7.0	5. 00		0	5. 00
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost proporting period (if calendar year, enter 0 on this line) 10.00 Intal swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SWF type inpatient days applicable to the Program (excluding private room days) 10.00 Swing-bed SWF type inpatient days applicable to the Title XVIII only (including private room days) 10.00 Swing-bed SWF type inpatient days applicable to the Title XVIII only (including private room days) after 10.00 Swing-bed SWF type inpatient days applicable to the Title XVIII only (including private room days) after 10.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed NF type inpatient days applicable to titles V or XXI only (including private room days) 11.00 Swing-bed NF type inpatient days applicable to titles V or XXI only (including private room days) 11.00 Swing-bed NF type inpatient days applicable to titles V or XXI only (including private room days) 11.00 Swing-bed NF type inpatient days applicable to titles V or XXI only (including private room days) 11.00 Swing-bed NF type inpatient days applicable to titles V or XXI only (including private room days) 11.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 11.00 Swing-bed Swing-	6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar 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
0.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to ititle XVIII only (including private room days) after 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 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) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Neurory days (title V or XIX only) 17.00 Medicaler rate for swing-bed SNF services applicable to services through December 31 of the cost One of the Cost reporting period (if calendar year, enter 0 on this line) 18.00 Neurory days (title V or XIX only) 19.00 Neurory days (title	8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
10.00 Swing-bed SNP type Inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNP type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNP type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed NP type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NP type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 SWING-BED ADUSTMENT 17.00 Mursery days (title V or XIX only) 18.00 Model care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 reporting period 19.00 Medical draft for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Model and the for swing-bed SNF services applicable to services after December 31 of the cost reporting period 20.00 Medical draft for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x I ine 19) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x I ine 19) 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x I ine 19) 25.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x I ine 19) 26.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x I ine 20) 27.00 General inpatient routine service cost (see instructions) 28.00 Swing-bed cost applicable to SN	9. 00		2, 905	9. 00
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days)  1.10 Osing-bed NT type inpatient days applicable to titles V or XIX only (including private room days)  1.10 Osing-bed NT type inpatient days applicable to titles V or XIX only (including private room days)  1.11 Osing-bed NT type inpatient days applicable to titles V or XIX only (including private room days)  1.12 Osing-bed NT type inpatient days applicable to titles V or XIX only (including private room days)  1.12 Osing-bed NT type inpatient days applicable to the Program (excluding swing-bed days)  1.12 Osing-bed NT type (including private room days)  1.13 Osing-bed NT type (including private room days)  1.14 Osing-bed Cost applicable to services applicable to services through December 31 of the cost  1.15 Osing-bed Osing-bed SNF services applicable to services after December 31 of the cost  1.15 Osing-bed Osing-bed SNF services applicable to services after December 31 of the cost  1.15 Osing-bed Osing-bed SNF services applicable to services after December 31 of the cost  1.15 Osing-bed Cost applicable to SNF type services through December 31 of the cost  1.16 Osing-bed Cost applicable to SNF type services through December 31 of the cost reporting period (line 6 os X Iline 17)  2.15 Osing-bed Cost applicable to SNF type services after December 31 of the cost reporting period (line 6 os X Iline 17)  2.16 Osing-bed Cost applicable to SNF type services after December 31 of the cost reporting period (line 6 os X Iline 17)  2.17 Osing-bed Cost applicable to SNF type services after December 31 of the cost reporting period (line 8 osing-bed Cost applicable to NF type services after December 31 of the cost reporting period (line 8 osing-bed Cost applicable to	40.00			40.00
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)   13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   14.00   Modically necessary private room days applicable to the Program (excluding swing-bed days)   14.00   Total nursery days (title V or XIX only)   15.00   Total nursery days (title V or XIX only)   16.00   Normary days (title V or XIX only)   17.00   Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (lace are rate for swing-bed SNF services applicable to services after December 31 of the cost (lace are rate for swing-bed NF services applicable to services after December 31 of the cost (lace are rate for swing-bed NF services applicable to services after December 31 of the cost (lace are rate for swing-bed NF services applicable to services after December 31 of the cost (lace are rate for swing-bed NF services applicable to services after December 31 of the cost (lace are rate for swing-bed NF services applicable to services after December 31 of the cost (lace are rate for swing-bed NF services applicable to services after December 31 of the cost (lace are rate for swing-bed NF services applicable to services after December 31 of the cost (lace are rate for swing-bed NF services after December 31 of the cost reporting period (line (lace are rate for swing-bed NF services after December 31 of the cost reporting period (line (lace are rate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line (lace are rate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line (lace are rate for swing-bed cost applicable to NF type services after December 31 of the	10.00	through December 31 of the cost reporting period (see instructions)	Ü	10.00
through December 31 of the cost reporting period  13.00 Marghed MF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days)  15.00  16.00 Novery days (title V or XIX only)  16.00  17.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost  17.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost  18.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Modical drate for swing-bed NF services after December 31 of the cost reporting period (line 5 x line 17)  20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  20.00 Swing-bed cost spplicable to NF type	11. 00		0	11. 00
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   13.00   13.00   14.00   Modically necessary private room days applicable to the Program (excluding swing-bed days)   0.14.00   15.00   16.00   18.00   1	12. 00		0	12. 00
14.00   Medically necessary private room 'days 'applicable' to the Program (excluding swing-bed days)   0   14.00   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   0   16.00   Nursery days (title V or XIX only)   17.00   18.00   SNING BED ADJUSTMENT   17.00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost   0.00   17.00   18.00   18.00   19.00	13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period sungle of the cost reporting period reporting reporting reporting reporting period reporting period reporting report reporting re	14. 00		0	14. 00
SWING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 reporting period medicare rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 reporting period reporting period supporting period supporting period reporting period reporting period reporting period supporting period reporting reporting reporting reporting reporting period reporting reporti	15. 00	Total nursery days (title V or XIX only)	0	15.00
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 reporting period 0.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 reporting period 0.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 0.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 0.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Swing-bed cost (see instructions) 0 25.00 Swing-bed cost (see instructions) 0 26.00 Total swing-bed cost (see instructions) 0 26.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 20.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 20.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 20.00 Semi-private room charges (excluding swing-bed charges) 0 20.00 33.00 33.00 34.00 Average peridem private room cost differential (line 37 x line 38) 0.00 35	16. 00		0	16.00
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period of Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period of Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period of reporting period of SNF type services applicable to services after December 31 of the cost reporting period (line 5 x line 17) of total general inpatient routine service cost (see instructions) 8, 968, 547 21.00 of SWing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18) wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) of the cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) of the cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) of the cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) of total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) of total swing-bed cost (see instructions) of the cost reporting period (line 8 x line 20) of total swing-bed cost (see instructions) of the cost reporting period (line 8 x line 20) of total swing-bed cost (see instructions) of the cost reporting period (line 8 x line 20) of total swing-bed cost (see instructions) of the cost reporting period (line 8 x line 20) of total swing-bed cost (see instructions) of the cost reporting period (line 8 x line 20) of total swing-bed cost (see instructions) of the cost reporting period (line 8 x line 20) of total swing-bed cost (see instructions) of to	17. 00		0.00	17. 00
reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 For invate room charges (excluding swing-bed and observation bed charges) 30.00 Semi-private room charges (excluding swing-bed and observation bed charges) 31.00 General inpatient routine service cost/charges (ine 29 + line 3) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average per diem private room charge (line 29 + line 3) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Proyram general inpatient routine service cost per diem (see instructions) 39.00 Proyram general inpatient routine service cost per diem (see instructions) 39.00 Proyram general inpatient routine service cost per diem (see instructions) 39.00 Proyram gen	18. 00		0. 00	18. 00
reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (1.0.00 20	19 00	reporting period		
reporting period Total general inpatient routine service cost (see instructions)  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Total swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions)  25.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average perivate room per diem charge (line 29 ÷ line 3)  33.00 Average peridiem private room per diem charge (line 30 ÷ line 4)  34.00 Average peridiem private room charge (line 30 ÷ line 4)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8 x line 38)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost tene of the report of the Program (line 14 x line 35)  40.00 Average per diem private room cost at perioa (line 9 x line 38)  39.00 Adjusted general inpatient routine service cost tene for the Program (line 14 x line 35)  40.00		reporting period		
22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Frivate room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average periouse room per diem charge (line 29 + line 3)  33. 00 Average per diem private room cost differential (line 30 + line 4)  34. 00 Average per diem private room cost differential (line 34 x line 31)  35. 00 Average per diem private room cost differential (line 34 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35)  37. 00 Average per diem private room cost differential (line 3 x line 35)  38. 00 Average per diem private room cost differential (line 3 x line 35)  38. 00 Average per diem private room cost differential (line 3 x line 35)  39. 00 Average per diem private room cost differential (line 3 x line 35)  39. 00 Program general inpatient routine service cost per diem (see instructions)  30. 00 Program general inpatient routine service cost per diem (see instructions)  30. 00 Program general inpatient routine service cost ter the Program (line 14 x line 35)  30. 00 Average per diem private room cost applicable to the Program (line 14 x line 35)  30. 00 Average per diem provent per diem charge (line 1		reporting period		
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  Observation of the cost reporting period (line 8 x line 20)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  Obsemi-private room charges (excluding swing-bed charges)  Obsemi-private room charges (excluding swing-bed charges)  Obsemi-private room charges (excluding swing-bed charges)  Obsemi-private room per diem charge (line 29 + line 3)  Obsemi-private room per diem charge (line 30 + line 4)  Obsemi-private room cost differential (line 32 minus line 33) (see instructions)  Obsemi-private room cost differential (line 34 x line 31)  Obsemi-private room cost differential (line 34 x line 31)  Obsemi-private room cost differential (line 34 x line 35)  Obsemi-private room cost differential (line 34 x line 35)  Obsemi-private room cost differential (line 34 x line 35)  Obsemi-private room cost differential (line 34 x line 35)  Obsemi-private room cost differential (line 34 x line 35)  Obsemi-private room cost differential (line 35 x line 35)  Obsemi-private room cost differential (line 35 x line 35)  Obsemi-private room cost differential (line 35 x line 35)  Obsemi-private room cost differential (line 35 x line 35)  Obsemi-private room cost differential (line 35 x line 35)  Obsemi-private room cost differential (line 35 x line 35)  Obsemi-private room cost differential (line 35 x line 35)  Obsemi-private room cost differential (line 35 x line 35)  Obsemi-private room cost differential (line 35 x		Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		
24. 00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  25. 00  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  30. 00  Semi-private room charges (excluding swing-bed charges)  30. 00  Semi-private room charges (excluding swing-bed charges)  30. 00  Semi-private room per diem charge (line 29 + line 3)  30. 00  Average per diem private room per diem charge (line 30 + line 4)  Average per diem private room cost differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 968, 547)  PRIVATE ROOM DIFFERENTIAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00  39. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0. 00  0.	23. 00		0	23. 00
7 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	24 00		0	24 00
x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average private room per diem charge (line 29 + line 3)  32. 00 Average semi-private room per diem charge (line 30 + line 4)  34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 968, 547)  PRIVATE ROOM DIFFERENTIAL ADD SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00		7 x line 19)		
27. 00   Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   8, 968, 547   27. 00     PRI VATE ROOM DIFFERENTIAL ADJUSTMENT   General inpatient routine service charges (excluding swing-bed and observation bed charges)   0   28. 00     Pri vate room charges (excluding swing-bed charges)   0   29. 00     30. 00   Semi-pri vate 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   Average pri vate room per diem charge (line 29 + line 3)   0.00     32. 00   Average semi-pri vate room per diem charge (line 30 + line 4)   0.00     33. 00   Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)   0.00   34. 00     34. 00   Average per diem pri vate room cost differential (line 34 x line 31)   0.00   35. 00     35. 00   Average per diem pri vate room cost differential (line 34 x line 35)   0.00   35. 00     37. 00   General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 27 minus line 36)   PART II - HOSPITAL AND SUBPROVIDERS ONLY   PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS   1, 268. 36   39. 00     39. 00   Program general inpatient routine service cost (line 9 x line 38)   3, 684, 586   39. 00     40. 00   Medically necessary pri vate room cost applicable to the Program (line 14 x line 35)   0   40. 00		x line 20)		
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 968, 547)  30.00 General inpatient routine service cost per diem (see instructions)  30.00 Adj usted general inpatient routine service cost per diem (see instructions)  30.00 Program general inpatient routine service cost per diem (see instructions)  30.00 Program general inpatient routine service cost per diem (see instructions)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  30.00 Vanious did charges			-	
28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30. 00 Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  30. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  31. 00 Average per diem private room cost differential (line 34 x line 31)  32. 00 Average per diem private room cost differential (line 3 x line 31)  33. 00 Average per diem private room cost differential (line 3 x line 35)  34. 00 Average per diem private room cost differential (line 3 x line 35)  35. 00 Average per diem private room cost differential (line 3 x line 35)  36. 00 Average per diem private room cost differential (line 3 x line 35)  37. 00 Average per diem private room cost differential (line 3 x line 35)  38. 00 Average per diem private room cost differential (line 8, 968, 547)  37. 00 Average per diem private room cost differential (line 8, 968, 547)  38. 00 Average per diem private room cost differential (line 8, 968, 547)  38. 00 Average per diem private room cost differential (line 8, 968, 547)  38. 00 Average per diem private room cost differential (line 8, 968, 547)  38. 00 Average per diem private room cost differential (line 8, 968, 547)  38. 00 Average per diem private room cost differential (line 8, 968, 547)  38. 00 Average per diem private room cost differential (line 8, 968, 547)  39. 00 Average per diem private room cost differential (line 8, 968, 547)  39. 00 Average per diem private room cost differential (line 8, 968, 547)  39. 00 Average per diem private room cost differential (line 8, 968, 547)  39. 00 Average per diem private room cost differential (line 8, 968, 547)  30. 00 Average per diem pr	27.00		0,700,017	27.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 968, 547) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 968, 547)  37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 00 00 00 00 00 00 00 00 00 00 00 00	29. 00			
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 968, 547)  27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 32.00 33.00 34.00 35.00 Average per diem private room cost differential (line 8, 968, 547) 0.00 34.00 35.00 36.00 37.00 Eneral inpatient routine service cost per diem (see instructions) 37.00 27 minus line 36) 28.00 37.00 28.00 38.00 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 968, 547)  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)  7.00 Program general inpatient routine service cost (line 9 x line 38)  8.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00 34.00  0.00 34.00  37.00 35.00  36.00  37.00 27 minus line 36)  8.968,547  37.00  37.00 36.00  37.00		i i		
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 968, 547)  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)  7.00 Program general inpatient routine service cost (line 9 x line 38)  8.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  9.00 Average per diem private room cost differential (line 33 x line 31)  9.00 See instructions)  9.00 Average per diem private room cost differential (line 34 x line 31)  9.00 Seneral inpatient routine service cost per diem (see instructions)  1, 268.36  3, 684, 586  9.00  40.00				
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 968, 547)  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)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 35.00 36.00 36.00 36.00 36.00 36.00 37.00 37.00				
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 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) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 37.00 8, 968, 547 37.00 37.00 37.00				
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37. 00  8, 968, 547  37. 00  8, 968, 547  1, 268. 36  38. 00  3, 684, 586  9, 00  40. 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)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 268.36 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	31.00	27 minus line 36)	0, 700, 047	37.00
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 268.36 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1, 268.36 3, 684, 586 39.00 40.00				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 3, 684, 586 39.00 40.00	20 00		1 2/0 2/	20 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
	41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	3, 684, 586	41. 00

	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
	Total general inpatient routine service cost (see instructions)	8, 968, 547	
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8, 968, 547	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
	Private room charges (excluding swing-bed charges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33. 00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	8, 968, 547	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, 268. 36	38. 00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3, 684, 586	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)	3, 684, 586	41.00
			•

MPUT	Financial Systems H ATION OF INPATIENT OPERATING COST		Provider C		Peri od:	w of Form CMS-2 Worksheet D-1	
					From 01/01/2015 To 12/31/2015	Date/Time Pre 2/15/2017 2:1	
				XVIII	Hospi tal	PPS	. pill
	Cost Center Description	Total Inpatient Costl	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	5	Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
. 00	NURSERY (title V & XIX only)	0	0	0.0	00 0	0	42.
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	2 527 7/0	1, 742	2, 025.	12 988	2, 000, 819	1 42
. 00	CORONARY CARE UNIT	3, 527, 760	1, 742	2, 025.	988	2,000,819	43. 44.
. 00	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT						46.
. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st D_3 col 3	line 200)			1. 00 6, 609, 327	48.
. 00	Total Program inpatient costs (sum of lines			ns)		12, 294, 732	
	PASS THROUGH COST ADJUSTMENTS			,		.=, =, ., .,	1
. 00	Pass through costs applicable to Program inp	atient routine s	services (from	Wkst. D, sum	of Parts I and	810, 281	50.
					6.5	0.40 004	
. 00	Pass through costs applicable to Program inp	atient ancillary	y services (fr	om Wkst. D, s	sum of Parts II	340, 331	51.
. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				1, 150, 612	52
. 00	Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	netist, and	11, 144, 120	
	medical education costs (line 49 minus line	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION						١.,
. 00	Program discharges Target amount per discharge					0.00	54
. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operat	ing cost and tai	rget amount (I	ine 56 minus	line 53)	Ö	
. 00	Bonus payment (see instructions)		. g (.			0	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period (	endi ng 1996, u	pdated and co	ompounded by the	0.00	59
00	market basket					0.00	
. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0. 00 0	
. 00	which operating costs (line 53) are less than					0	
	amount (line 56), otherwise enter zero (see		3 (TTHES OT X	00), 01 1% 01	the target		
. 00	Relief payment (see instructions)					0	62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dosor	mbor 21 of the	cost roporti	ng poriod (Soo	0	64
. 00	instructions)(title XVIII only)	ts through becer	iliber 31 of the	cost reporti	ng perrou (see		04
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line d	64 plus line 6	5)(title XVII	I only). For	0	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	a costs through	December 31 o	f the cost re	norting period	0	67
. 00	(line 12 x line 19)	e costs through	December 31 0	i the cost re	portring perrou	0	0'
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost repo	orting period	0	68
	(line 13 x line 20)						
. 00	Total title V or XIX swing-bed NF inpatient					0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil						70
. 00	Adjusted general inpatient routine service c						71
. 00	Program routine service cost (line 9 x line			_,			72
. 00	Medically necessary private room cost applic	5	•	,			73
. 00	Total Program general inpatient routine serv	•	,				74
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from W	orksheet B, F	art II, column		75
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minu	,					78
00	Aggregate charges to beneficiaries for exces				1: 70`		79
00	Total Program routine service costs for comp		ost limitation	(line /8 mir	ius iine /9)		80
00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				82
00	Reasonable inpatient routine service costs (						83
. 00	Program inpatient ancillary services (see in		•				84
	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (sum		rough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					1 // 4	07
	Total observation bed days (see instructions	)				1, 664	87
. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 268. 36	88

Health Financial Systems HE	ENRY COUNTY MEN	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Prep 2/15/2017 2:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	1, 299, 800	8, 968, 547	0. 14492	9 2, 110, 551	305, 880	90.00
91.00 Nursing School cost	0	8, 968, 547	0.00000	2, 110, 551	0	91.00
92.00 Allied health cost	0	8, 968, 547	0. 00000	2, 110, 551	0	92.00
93.00 All other Medical Education	0	8, 968, 547	0. 000000	2, 110, 551	0	93. 00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lie	eu of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-003	From 01/01/2015	Worksheet D-1 Date/Time Pre 2/15/2017 2:1	pared:
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
INDATIENT DAVS				1

		Title XIX	Hospi tal	Cost	, p
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		7, 071	1. 00
2.00	Inpatient days (including private room days, excluding swing-	ped and newborn days)		7, 071	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	/s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		5, 407	4. 00
5.00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through December	31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	191	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)	nter O on this line)	,	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	3 .	,	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this line	e) , ,	0	14. 00
15. 00	Total nursery days (title V or XIX only)	alli (excruding swing-bed to	lays)	- 1	15. 00
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 service	es through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions			8, 968, 547	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ line 17)	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December (x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost   PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		8, 968, 547	27. 00
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x lin			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 a	and private room cost di	fferential (line	8, 968, 547	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 268. 36	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		242, 257	39. 00
	Medically necessary private room cost applicable to the Progra	,		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ IINE 4U)		242, 257	41.00

	Financial Systems FATION OF INPATIENT OPERATING COST	HENRY COUNTY MEM	Provider C		Period:	w of Form CMS- Worksheet D-	
					From 01/01/2015 To 12/31/2015		
						2/15/2017 2:	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	,	Inpatient Cost		Diem (col. 1		(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1, 330, 404	812				42.00
43. 00	Intensive Care Type Inpatient Hospital Uni INTENSIVE CARE UNIT	3, 527, 760	1, 742	2, 025. 1	2 0	(	43. 00
44. 00		3, 327, 700	1, 742	2,023. 1	0	·	44. 00
45. 00							45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description			l			
48. 00	Program inpatient ancillary service cost	(Wkst D-3 col 3	line 200)			1. 00 105, 53	7 48.00
	Total Program inpatient costs (sum of line	•		ns)		347, 79	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program	inpatient routine	services (Trom	WKST. D, SUM	or Parts I and	(	50.00
51. 00	Pass through costs applicable to Program	inpatient ancillar	y services (fr	om Wkst. D, s	um of Parts II	(	51.00
52. 00	and IV) Total Program excludable cost (sum of line	es 50 and 51)				,	52.00
53. 00	Total Program inpatient operating cost exc	cluding capital re	lated, non-phy	sician anesth	etist, and		53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	ne 52)					
54. 00	Program discharges					(	54.00
	Target amount per discharge						55. 00
56. 00 57. 00	,	rating cost and ta	rget amount (L	ine 56 minus	line 53)		56. 00 57. 00
58. 00	Bonus payment (see instructions)	Ü			•	(	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost market basket	reporting period	endi ng 1996, u	pdated and co	empounded by the	0.00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year	ar cost report, up	dated by the m	arket basket		0.00	60.00
61. 00						(	61. 00
	which operating costs (line 53) are less amount (line 56), otherwise enter zero (so		S (TITIES 54 X	60), OI 1% OI	the target		
	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive particles PROGRAM INPATIENT ROUTINE SWING BED COST	ayment (see instru	CTI ONS)				63. 00
64. 00	Medicare swing-bed SNF inpatient routine	costs through Dece	mber 31 of the	cost reporti	ng period (See	(	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine</pre>	costs after Decemb	er 31 of the c	ost reporting	period (See	(	65. 00
	instructions) (title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient rou CAH (see instructions)	utine costs (line	64 plus line 6	5)(title XVII	I only). For	(	66. 00
67. 00	Title V or XIX swing-bed NF inpatient rou	tine costs through	December 31 o	f the cost re	porting period	(	67. 00
40 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient rou	tino costs after D	ocombor 21 of	the cost rong	urting pariod	,	49 00
00. 00	(line 13 x line 20)	tille costs after b	ecember 31 or	the cost repo	irting perrou	(	68. 00
69. 00	Total title V or XIX swing-bed NF inpatie					(	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing fac						70. 00
71. 00	Adjusted general inpatient routine service	e cost per diem (I					71.00
72. 00 73. 00	Program routine service cost (line 9 x lin Medically necessary private room cost appl		(line 14 v li	ne 35)			72. 00 73. 00
74. 00							74. 00
75. 00	· ·	nt routine service	costs (from W	orksheet B, P	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷	line 2)					76. 00
77. 00	Program capital -related costs (line 9 x li						77. 00
78. 00 79. 00	,		rovi der record	s)			78. 00 79. 00
80. 00	Total Program routine service costs for co	omparison to the c			us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem li Inpatient routine service cost limitation		)				81. 00 82. 00
83. 00	Reasonable inpatient routine service cost	* .	•				83. 00
84. 00	Program inpatient ancillary services (see		>				84.00
85. 00 86. 00	1 3 1						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED F	PASS THROUGH COST	/				
87. 00	Total observation bed days (see instruction Adjusted general inpatient routine cost po		line 2)			1, 664 1, 268. 30	1
88. 00	Trial as tou goneral lineations foulline COST be	or arom (TITE Z/ =	1 1 1 1 C Z J			1,200.30	, UU. UU

Health Financial Systems HE	ENRY COUNTY MEN	IORI AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Prep 2/15/2017 2:1	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	1, 299, 800	8, 968, 547	0. 14492	9 2, 110, 551	305, 880	90.00
91.00 Nursing School cost	0	8, 968, 547	0.00000	2, 110, 551	0	91.00
92.00 Allied health cost	0	8, 968, 547	0. 00000	2, 110, 551	0	92.00
93.00 All other Medical Education	0	8, 968, 547	0. 000000	2, 110, 551	0	93. 00

Health Financial Systems HENRY CO INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	UNTY MEMORIAL HOSPITAL			eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od: From 01/01/2015	Worksheet D-3	
			To 12/31/2015	Date/Time Pre	
	T' 11	V0.41.1		2/15/2017 2:1	1 pm
Cook Cooks Doors at the	IITIE	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cost To Charges	t Inpatient Program	Inpatient Program Costs	
		10 Charges	Charges	(col. 1 x col.	
			Chai ges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	·	1.00	2.00	0.00	
30. 00   03000   ADULTS & PEDI ATRI CS			3, 631, 908		30.00
31. 00 03100 I NTENSI VE CARE UNI T			2, 409, 067		31.00
41. 00   04100   SUBPROVI DER -   RF			0		41.00
42. 00   04200   SUBPROVI DER			0		42.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS		•			
50. 00 05000 OPERATING ROOM		0. 27952	2 2, 598, 175	726, 247	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 20411	1 5, 970	1, 219	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 26558	9 852, 440	226, 399	54.00
57. 00   05700   CT   SCAN		0. 02878			
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0. 06907		6, 271	
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 80817			
60. 00   06000   LABORATORY		0. 26467			
60. 01   06001   BL00D LABORATORY		0.00000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 23348		210, 179	
66. 00   06600   PHYSI CAL THERAPY		0. 65627		230, 840	
68. 00 O6800 SPEECH PATHOLOGY		0. 87276		13, 176	
69. 00   06900   ELECTROCARDI OLOGY		0. 10989			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 11113			
72. 00   07200   I MPL. DEV. CHARGED TO PATIENT		0. 46228			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 16642			
76. 00 03950 CARDI AC REHAB		0. 78636	2  0	0	76.00
OUTPATIENT SERVICE COST CENTERS		0.00000		_	00.00
88. 00   08800   RURAL HEALTH CLINIC 89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER		0. 00000 0. 00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000			

0. 447599

1. 175268

506, 001 230, 123 25, 309, 813

25, 309, 813

91.00

201. 00

202. 00

226, 486 270, 456

270, 456 92. 00 6, 609, 327 200. 00

91.00

200.00

201.00 202.00

09100 EMERGENCY

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

Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net Charges (line 200 minus line 201)

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL			u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 1		Period: From 01/01/2015	Worksheet D-3	
			To 12/31/2015	Date/Time Pre	nared.
				2/15/2017 2:1	
	Title XII		Hospi tal	Cost	
Cost Center Description		io of Cost		I npati ent	
	То	Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LABORE ENT. DOUTLING OFFICE OF COST, OFFITEDO		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			0/4 50/		
30. 00 03000 ADULTS & PEDI ATRI CS			264, 526		30.00
31. 00 03100 I NTENSI VE CARE UNI T			50, 747		31.00
41. 00   04100   SUBPROVI DER -			0		41.00
42. 00 04200 SUBPROVI DER			70.004		42.00
43. 00 04300 NURSERY			79, 326		43. 00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM		0. 27952	2 0	0	50. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 27952.		0	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	ł	0. 26558		- 1	54. 00
57. 00   05700 CT SCAN	ł	0. 02878			57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 02878			58. 00
59. 00 05900 CARDIAC CATHETERIZATION		0. 80817	· ·	2, 446	
60. 00   06000   LABORATORY		0. 26445	· ·	27, 374	
60. 01 06001 BLOOD LABORATORY		0. 000000		27, 374	60. 01
65. 00 06500 RESPIRATORY THERAPY		0. 23348		4, 304	
66. 00 06600 PHYSI CAL THERAPY		0. 65627			66. 00
68. 00 06800 SPEECH PATHOLOGY		0. 87276	· ·	·	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 10989:	· ·	471	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	S	0. 11113	· ·	21, 814	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 46228		0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 166420		39, 802	73. 00
76. 00   03950   CARDI AC   REHAB		0. 78636	· ·	0	76. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0. 000000	0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	0	0	89. 00
91 00 09100 EMERGENCY		0 44750	ol n	n	01 00

0. 447599

1. 175268

0 0 0

615, 518

615, 518

92. 00 0

201. 00

202. 00

0 91.00

105, 537 200. 00

91.00

200.00

201.00

202.00

09100 EMERGENCY

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

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0030		Worksheet E Part A Date/Time Prepared: 2/15/2017 2:11 pm

				2/15/2017 2: 1	1 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring instructions)	prior to October 1 (s	see	0 5, 942, 749	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	on or after October	(see	2, 161, 586	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	discharges occurring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	di scharges occurri ng o	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			126, 786 0	2. 00 2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instruction	s)		0	2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporti	ng period (see instru	ctions)	0 43. 44	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most r	recent cost reporting p	period ending on	0.00	5. 00
6. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs which meet the for new programs in accordance with 42 CFR 413.79(e)	criteria for an add-d	on to the cap	0.00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified und			0.00	7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified un If the cost report straddles July 1, 2011 then see instructions.	der 42 CFR §412.105(f)	(1) (i v) (B) (2)	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathi affiliated programs in accordance with 42 CFR 413.75(b), 413.79(1998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots the cost report straddles July 1, 2011, see instructions.	under section 5503 of	the ACA. If	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots under section 5506 of ACA. (see instructions)	from a closed teaching	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)	(8, 8,01 and 8,02) (s	see	0. 00	9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the current FTE count for residents in dental and podiatric programs.	year from your record	ls	0. 00 0. 00	10. 00 11. 00
12.00	Current year allowable FTE (see instructions)				12.00
13. 00 14. 00	Total allowable FTE count for the prior year.  Total allowable FTE count for the penultimate year if that year	ended on or after Sep	ember 30, 1997,	0. 00 0. 00	
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.				15. 00
16.00	Adjustment for residents in initial years of the program			0.00	
17. 00 18. 00	Adjustment for residents displaced by program or hospital closur	e		0.00	17. 00 18. 00
19. 00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0.000000	
20. 00	Prior year resident to bed ratio (see instructions)			0. 000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22. 00	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 Section Number of additional allopathic and osteopathic IME FTE resident	422 of the MMA cap slots under 42 Se	ec. 412.105	0.00	23. 00
	(f)(1)(iv)(C).				
24. 00	IME FTE Resident Count Over Cap (see instructions)	6.1. 00 1.	04.6		24.00
25. 00	If the amount on line 24 is greater than -O-, then enter the low instructions)	er of line 23 or line	24 (see	0. 00	25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 01
30. 00	<u>Disproportionate Share Adjustment</u> Percentage of SSI recipient patient days to Medicare Part A pati	ent days (see instruct	ions)	5. 58	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	chi days (see Thistiluc	.1 0113)	20. 60	1
31.00	Sum of Lines 30 and 31			26. 18	32.00
	Allowable disproportionate share percentage (see instructions)			10. 81	
	Disproportionate share adjustment (see instructions)			219, 020	
5 55	12pp-1. 1. 3.1.4.5 3.1.4. 5 day 43.1.1.3.11 (300 111311 4011 6113)		I	217, 020	

CVI CIII	Financial Systems HENRY COUNTY MEM  ATION OF REIMBURSEMENT SETTLEMENT	ORIAL HOSPITAL Provider CCN: 15-0030	Peri od:	u of Form CMS-2 Worksheet E	2552-11
CALCUL	ATTON OF REIMBORSEMENT SETTLEMENT	Provider CCN. 15-0030	From 01/01/2015	Part A	
			To 12/31/2015	Date/Time Pre 2/15/2017 2:1	
	<u> </u>	Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35. 00			7, 647, 644, 885		
35. 01 35. 02		enter zero on this line)	0. 000061204 468, 065	0. 000060127 385, 179	35. 01 35. 02
	(see instructions)	,		•	
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment a Total uncompensated care (sum of columns 1 and 2 on line 35		350, 087 446, 908	96, 821	35. 03 36. 00
30. 00	Additional payment for high percentage of ESRD beneficiary	discharges (lines 40 throu			30.00
40. 00	Total Medicare discharges on Worksheet S-3, Part I excludin		0		40. 00
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683 684 an 685 (see	0		41.00
11.00	instructions)	000, 001 an 000. (300			11.00
41. 01	Total ESRD Medicare covered and paid discharges excluding M an 685. (see instructions)	IS-DRGs 652, 682, 683, 684	0		41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qua	lify for adjustment)	0.00		42.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43. 00
44. 00	instructions) Ratio of average length of stay to one week (line 43 divide	d by line 41 divided by 7	0. 000000		44. 00
00	days)	3	0.00000		
45. 00 46. 00	Average weekly cost for dialysis treatments (see instructio Total additional payment (line 45 times line 44 times line		0.00		45. 00 46. 00
47. 00	Subtotal (see instructions)	41.01)	8, 897, 049		47. 00
48. 00		small rural hospitals	10, 489, 688		48. 00
	only. (see instructions)			Amount	
				1. 00	
49.00	Total payment for inpatient operating costs (see instruction			10, 091, 528	•
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I Exception payment for inpatient program capital (Wkst. L, P			667, 204 0	50. 00 51. 00
52. 00	Direct graduate medical education payment (from Wkst. E-4,			0	52.00
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0	53. 00 54. 00
54. 01	Islet isolation add-on payment			O	54.00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	*		0	
56. 00 57. 00				0	56. 00 57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt		in odgir oo).	0	
59. 00	Total (sum of amounts on lines 49 through 58)			10, 758, 732	
60. 00 61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 min	us line 60)		0 10, 758, 732	60. 0 61. 0
62. 00	Deductibles billed to program beneficiaries	33)		1, 013, 904	
63. 00	Coinsurance billed to program beneficiaries			10, 710	
64. 00 65. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			68, 967 44, 829	1
66. 00	Allowable bad debts for dual eligible beneficiaries (see in	structions)		37, 042	1
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	1: 11 1 MC DDG (		9, 778, 947	67.0
68. 00 69. 00	Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96			0	68. 0 69. 0
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	, ( ). 21 230 (	- /	0	70. 0
70. 50	RURAL DEMONSTRATION PROJECT			0	70.5
70. 88 70. 89	SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see in	structions)		0	70. 8 70. 8
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)	*		9, 097	70. 9
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			-6, 119	
70. 92 70. 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 62, 393	
70. 73				-41, 385	70. 94
	Recovery of accelerated depreciation				70. 9!

ealth Financial Systems HENRY COUNTY M CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der Co	CN: 15-0030	Peri od: From 01/01/2015 To 12/31/2015	u of Form CMS-2 Worksheet E Part A Date/Time Pre 2/15/2017 2:1	pared:
	Title	XVIII	Hospi tal	PPS	. р
			(yyyy)	Amount	
			0	1, 00	
0.96 Low volume adjustment for federal fiscal year (yyyy) (Ent			2015	621, 624	70. 96
the corresponding federal year for the period prior to 10.097 Low volume adjustment for federal fiscal year (yyyy) (Ent			2016	293, 962	70. 97
the corresponding federal year for the period ending on c			20.0	270, 702	, 0. , ,
O. 98 Low Volume Payment-3				0	70. 98
O. 99 HAC adjustment amount (see instructions)				0	70. 99
1.00 Amount due provider (line 67 minus lines 68 plus/minus li	nes 69 & 70)			10, 718, 519	71.00
11.01   Sequestration adjustment (see instructions)				214, 370	71. 01
2.00 Interim payments				10, 502, 588	72.00
3.00 Tentative settlement (for contractor use only)				0	73.00
4.00 Balance due provider (Program) (line 71 minus lines 71.01	, 72, and 73)			1, 561	74.00
5.00 Protested amounts (nonallowable cost report items) in acc	ordance with			199, 243	75. 00
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see	e instructions)			0	
1.00 Capital outlier from Wkst. L, Pt. I, line 2				0	
22.00 Operating outlier reconciliation adjustment amount (see i				0	92.00
3.00  Capital outlier reconciliation adjustment amount (see ins	structi ons)			0	93.00
4.00 The rate used to calculate the time value of money (see i	nstructions)			0.00	94.00
75.00 Time value of money for operating expenses (see instructi	ons)			0	
6.00 Time value of money for capital related expenses (see ins	structions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
HSP Bonus Payment Amount 00.00 HSP bonus amount (see instructions)			893, 405	301, 074	100 00
			893, 405	301, 074	100.00
HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions)			1. 0061912615	1. 0118431517	101 00
02.00 HVBP adjustment factor (see instructions)	stions)		5, 531		101.00
HRR Adjustment for HSP Bonus Payment (see Instruc	. [ ] ( ) ( )		5, 531	3, 500	102.00
03.00 HRR adjustment factor (see instructions)			0. 9946	0. 9957	103 00
04.00 HRR adjustment amount for HSP bonus payment (see instruct			-4, 824	-1, 295	

In Lieu of Form CMS-2552-10

Period: Worksheet E
From 01/01/2015 Part A Exhibit 4
To 12/31/2015 Date/Time Prepared: 2/15/2017 2:11 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0030

					'	0 12/31/2015	2/15/2017 2:1	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	On/After 10/01 4.00	through 4) 5.00	
1. 00	DRG amounts other than outlier	1. 00	1.00	2.00	3.00		0.00	1. 00
	payments	00	ا	J				
1. 01	DRG amounts other than outlier payments for discharges	1. 01	5, 942, 749	0	5, 942, 749		5, 942, 749	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	2, 161, 586	0		2, 161, 586	2, 161, 586	1. 02
1. 03	1 DRG for Federal specific	1. 03	0	0	0		0	1. 03
	operating payment for Model 4 BPCI occurring prior to October 1							
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	2. 00	126, 786	0	113, 825	12, 961	126, 786	2. 00
2. 01	discharges (see instructions) Outlier payments for	2. 02	o	0	0	0	0	2. 01
	discharges for Model 4 BPCI	2. 02	0	0	0	0	0	
3. 00	Operating outlier reconciliation		0	0	0	0	0	3.00
4.00	Managed care simulated payments	3. 00	U	0	0	U	0	4. 00
5. 00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
3.00	A, line 21 (see instructions)	21.00	0.000000	0.000000	0.00000	0.00000		3.00
6. 00	IME payment adjustment (see instructions)	22. 00	О	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
	instructions)							
	Indirect Medical Education Adju	stment for the	Add-on for Se	ction 422 of t	he MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	О	0	0	O	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	0	0	O	0	8. 01
9. 00	instructions) Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed	29. 01	0	0	0	0	0	9. 01
	care (sum of lines 6.01 and 8.01)							
10.00	Di sproporti onate Share Adjustme Allowable di sproporti onate	ant 33. 00	0. 1081	0. 1081	0. 1081	0. 1081		10. 00
10.00	share percentage (see instructions)	33.00	0. 1081	0. 1061	0. 1061	0. 1061		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	219, 020	0	160, 603	58, 417	219, 020	11. 00
11. 01	Uncompensated care payments	36. 00	446, 908	0	350, 087	96, 821	446, 908	11. 01
	Additional payment for high per	centage of ESF						
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	8, 897, 049 10, 489, 688	0	6, 567, 264 7, 655, 854		8, 897, 049 10, 489, 688	
, 00	(completed by SCH and MDH, small rural hospitals only.)		. 1, 137, 330		1, 355, 361	_, 335, 301	12, 167, 300	
15. 00	Total payment for inpatient operating costs (see	49. 00	10, 091, 528	0	7, 383, 706	2, 707, 822	10, 091, 528	15. 00
16. 00	instructions) Payment for inpatient program capital	50. 00	667, 204	0	492, 030	175, 174	667, 204	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01	Net organ aquisition cost	55.00	О	0	0	o	0	17. 01
17. 02	Credits received from manufacturers for replaced	68. 00	0	0	0	0	0	17. 02
18. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see	93. 00	0	0	0	0	0	18. 00
	instructions)	<u> </u>	<u> </u>		<u> </u>	1	<u> </u>	

near tir Frhanciai S	Hearth Financial Systems Henry County Memo					In Lie	u or form cws-2	2002-10
LOW VOLUME CALCULA	TION EXHIBIT 4				Provider CCN: 15-0030		Date/Time Pre 2/15/2017 2:1	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
19.00 SUBTOTAL				0	7, 875, 736	5 2, 882, 996	10, 758, 732	19.00
·		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3.00	4. 00	5. 00	
20.00 Capital DRG	other than outlier	1.00	648, 100	0	474, 92	1 173, 179	648, 100	20. 00
20. 01 Model 4 BPC	I Capital DRG other	1. 01	o	0		0	0	20. 01
than outlie								
21.00 Capital DRG	outlier payments	2. 00	19, 104	0	17, 109	1, 995	19, 104	21.00
	l Capital DRG	2. 01	0	0		0	0	•
outlier pay								
	dical education	5. 00	0. 0000	0.0000	0. 0000	0.0000		22. 00
	(see instructions)							
	dical education	6. 00	o	0		0	0	23. 00
	(see instructions)						_	
	i sproporti onate	10.00	0. 0000	0.0000	0. 0000	0.0000		24.00
share percei								
instruction								
25.00 Disproporti		11.00	0	0		0	0	25. 00
	(see instructions)						_	
	ective capital	12.00	667, 204	0	492, 030	175, 174	667, 204	26.00
	ee instructions)		,		,			
		W/S E, Part A	(Amounts to E.					
		line	Part A)					
		0	1.00	2.00	3.00	4. 00	5. 00	
27. 00 Low volume a	adjustment factor				0. 078929	0. 101964		27. 00
28.00 Low volume a		70. 96			621, 624	4	621, 624	28. 00
	mount to Wkst. E,				, ,		,	
Pt. A, line								
29.00 Low volume		70. 97				293, 962	293, 962	29. 00
	mount to Wkst. E,						•	
Pt. A, line								
100.00 Transfer Lo			Υ					100.00
	to Wkst. E, Pt. A.							
1 3	•	•	. '		•	1	•	

Provider CCN: 15-0030

Peri od:

From 01/01/2015

Part A Exhibit 5

Date/Time Prepared: 12/31/2015 2/15/2017 2:11 pm Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 5, 942, 749 1.01 1.01 5, 942, 749 5, 942, 749 1.01 discharges occurring prior to October 1 DRG amounts other than outlier payments for 1.02 1.02 2, 161, 586 2, 161, 586 2, 161, 586 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 С 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 126, 786 113, 825 12, 961 126, 786 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 2.01 Operating outlier reconciliation 3 00 2 01 O 0 0 3 00 4.00 Managed care simulated payments 3.00 0 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 0 0 6.01 22.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 7.00 IME payment adjustment factor (see 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 8.01 28.01 0 0 8.01 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 9.00 9.01 Total IME payment for managed care (sum of 29.01 C 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage 10.00 0.1081 0. 1081 0.1081 10.00 33.00 (see instructions) 219, 020 11.00 Disproportionate share adjustment (see 34.00 219,020 160, 603 58.417 11.00 instructions) 11.01 Uncompensated care payments 36.00 446, 908 350, 087 96, 821 446, 908 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12 00 12 00 46 00 0 instructions) 13.00 Subtotal (see instructions) 47.00 8, 897, 049 6, 567, 264 2, 329, 785 8, 897, 049 13.00 14.00 Hospital specific payments (completed by SCH 48.00 10, 489, 688 14.00 and MDH, small rural hospitals only.) (see instructions) 10, 091, 528 Total payment for inpatient operating costs 15.00 49.00 9, 509, 082 582, 446 10, 091, 528 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 667, 204 494, 025 173, 179 667, 204 16.00 Special add-on payments for new technologies 17.00 54.00 17.00 55.00 Net organ acquisition cost 17.01 17.01 0 0 0 17.02 Credits received from manufacturers for 68.00 0 0 0 17.02 C replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18.00 93.00 0 18.00 amount (see instructions) 10, 003, 107 19 00 SUBTOTAL 755 625 10, 758, 732 19. 00

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (HAC)	REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0030		Worksheet E

From 01/01/2015 Part A Exhibit 5
To 12/31/2015 Date/Time Prepared: 2/15/2017 2:11 pm Title XVIII Hospi tal PPS Wkst. L, line (Amt. from L) Wkst. 2.00 3. 00 4.00 n 1 00 20.00 Capital DRG other than outlier 1.00 648, 100 474, 921 173, 179 648, 100 20.00 20.01 Model 4 BPCI Capital DRG other than outlier 1.01 20.01 Capital DRG outlier payments 21.00 2.00 19, 104 19, 104 0 19, 104 21.00 21.01 Model 4 BPCI Capital DRG outlier payments 2.01 21.01 0 0 22.00 Indirect medical education percentage (see 5.00 0.0000 0.0000 0.0000 22.00 instructions) 23. 00 23.00 Indirect medical education adjustment (see 6.00 0 instructions) 0.0000 0.0000 24.00 24 00 Allowable disproportionate share percentage 10 00 0 0000 (see instructions) 25.00 Disproportionate share adjustment (see 11.00 0 25.00 instructions) Total prospective capital payments (see 12.00 494, 025 173, 179 667, 204 667, 204 26.00 instructions) Wkst. E, Pt. (Amt. from A, line Wkst. E, Pt. A) 0 1.00 2.00 3. 00 4.00 27. 00 27. 00 28.00 Low volume adjustment prior to October 1 70.96 621, 624 621, 624 621, 624 28.00 29.00 Low volume adjustment on or after October 1 70.97 293, 962 293, 962 293, 962 29.00 HVBP payment adjustment (see instructions) 70. 93 62, 393 36, 793 25, 600 62, 393 30.00 30.00 30.01 HVBP payment adjustment for HSP bonus 70.90 9.097 5.531 3.566 9, 097 30.01 payment (see instructions) 31.00 HRR adjustment (see instructions) 70.94 -41, 385 -32, 091 -9, 294 -41, 385 31.00 HRR adjustment for HSP bonus payment (see 70. 91 -6, 119 -4, 824 -1, 295 -6, 119 31.01 31.01 instructions) (Amt. to Wkst. E, Pt. A) 2.00 3.00 0 1.00 4.00 32.00 HAC Reduction Program adjustment (see 70.99 0 32.00 instructions) 100.00 Transfer HAC Reduction Program adjustment to 100.00 Ν Wkst. E, Pt. A.

Health Financial Systems	HENRY COUNTY MEMORIA	L HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	F	Provider CCN: 15-0030	Peri od: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 2/15/2017 2:11 pm

			To 12/31/2015	Date/Time Pre 2/15/2017 2:1	
		Title XVIII	Hospi tal	PPS	ı pııı
				4.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			4, 556	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		7, 720, 654	2. 00
3.00	PPS payments			7, 318, 704	3. 00
4.00	Outlier payment (see instructions)			14, 923	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	
6.00	Line 2 times line 5			0	6. 00
7. 00 8. 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	7. 00 8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. 1	IV col 13 line 200		0	9. 00
10. 00	Organ acquisitions	11, 601. 10, 11116 200		0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			4, 556	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12.00	Ancillary service charges	no (0)		27, 376	
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li Total reasonable charges (sum of lines 12 and 13)	ne 69)		0 27, 376	
14.00	Customary charges			27, 370	14.00
15. 00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(	e)	_		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00	Total customary charges (see instructions)	ly if lime 10 eyesede li	no 11) (coo	27, 376	
19. 00	Excess of customary charges over reasonable cost (complete onlinstructions)	y II II'lle 18 exceeds II	ne ii) (see	22, 820	19. 00
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)				
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)			21. 00
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see insti	sustions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	uctions)		7, 333, 627	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			7, 333, 027	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			1, 617, 875	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) protected in the sum of lines 25 and 26)	olus the sum of lines 22	! and 23] (see	5, 720, 308	27. 00
28. 00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, li</pre>	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			5, 720, 308	30. 00
31. 00	Primary payer payments			1, 809	
32. 00	Subtotal (line 30 minus line 31)	250)		5, 718, 499	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	ES)		0	33. 00
34. 00	Allowable bad debts (see instructions)			290, 353	
35. 00	Adjusted reimbursable bad debts (see instructions)			188, 729	
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		239, 567	
37. 00	Subtotal (see instructions)			5, 907, 228	
38. 00	MSP-LCC reconciliation amount from PS&R				38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	- >		0	
39. 50 39. 98	Prioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replace		etions)	0	
39. 90	RECOVERY OF ACCELERATED DEPRECIATION	Led devices (see Tristruc	.trons)	0	39. 96 39. 99
40. 00	Subtotal (see instructions)			5, 907, 334	
40. 01	Sequestration adjustment (see instructions)	118, 147	40. 01		
41.00	Interim payments	5, 774, 070	41.00		
42. 00					42. 00
43. 00	00 Balance due provider/program (see instructions)			15, 117	
44. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92.00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	
74. UU	Total (sum of lines 91 and 93)		ı	0	94. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet E-1 |
| From 01/01/2015 | Part |
| To 12/31/2015 | Date/Time Prepared: | 2/15/2017 2:11 pm | Health Financial Systems HENRY OF ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 15-0030

			'	12, 01, 2010	2/15/2017 2: 11	1 pm
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		10, 510, 531	1	5, 601, 763	1. 00
2.00	Interim payments payable on individual bills, either				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					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2015	28, 160	12/31/2015	155, 331	3. 01
3. 02			(		27, 700	3. 02
3.03			(		0	3. 03
3.04			(		0	3. 04
3.05			(		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	08/05/2016	36, 103	08/05/2016	10, 724	3. 50
3. 51			(		0	3. 51
3.52			(		0	3. 52
3.53			(		0	3. 53
3.54			(		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		-7, 943	3	172, 307	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		10, 502, 588	3	5, 774, 070	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR	I				
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER			1	1 0	5. 01
5. 02	TENTATIVE TO PROVIDER					5. 01
5. 02						5. 02
5.05	Provider to Program			7	0	3.03
5. 50	TENTATI VE TO PROGRAM				0	5. 50
5. 51						5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
3. , ,	5. 50-5. 98)					] ", , ,
6.00	Determined net settlement amount (balance due) based on					6.00
50	the cost report. (1)					] 5. 50
6. 01	SETTLEMENT TO PROVIDER		1, 561	ı	15, 117	6. 01
6. 02	SETTLEMENT TO PROGRAM		(		0	6. 02
7. 00	Total Medicare program liability (see instructions)		10, 504, 149		5, 789, 187	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			)	1. 00	2.00	

Heal th	Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu o					
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 15-0030 Period: From 01/01/2015 Part To 12/31/2015 Date 2/15					
	Title XVIII Hospital PPS					
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			2, 174	1. 00	
1. 00	1.00   Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12		3, 893		
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			840	3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12		7, 149	4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			187, 235, 762	5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20		1, 949, 121	6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I	0	7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)			368, 786	8. 00	
9.00	Sequestration adjustment amount (see instructions)			7, 376	9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		361, 410	10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			323, 506	30. 00	
31.00	Other Adjustment (specify)			0	31. 00	
22 00	Polones due provider (line 0 (en line 10) minus line 20 and l	ing 21) (oss instruction	۵۱	27 004	22 00	

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

323, 506 30. 00 0 31. 00 37, 904 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: From 01/01/2015 To 12/31/2015 Worksheet E-3 Part VII Date/Time Prepared	

			lo 12/31/2015	Date/lime Pre 2/15/2017 2:1	
		Title XIX	Hospi tal	Cost	ı pııı
			Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		347, 794		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)		347, 794	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)		347, 794	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		394, 599		8. 00
9.00	Ancillary service charges		615, 518	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10. 00
11.00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 010, 117	0	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basi s				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
45.00	a charge basis had such payment been made in accordance with	12 CFR §413.13(e)			45.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	1
16.00	Total customary charges (see instructions)	. 6 1 . 4	1, 010, 117	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete onl	y IT line 16 exceeds	662, 323	0	17. 00
18. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete onl	vifling 4 avecade line	0	0	18. 00
18.00	16) (see instructions)	y II IIIle 4 exceeds IIIle		Ü	18.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instr	cuctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		347, 794	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.00
22. 00	Other than outlier payments	compreted for 113 provide	0	0	22.00
	Outlier payments		0	0	
24. 00	Program capital payments		0	Ü	24.00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	1
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		347, 794	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	l .	347, 794	0	31. 00
32.00	Deducti bl es		0	0	32. 00
33.00	Coi nsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	347, 794	0	36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		347, 794	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		347, 794	0	40. 00
41. 00	Interim payments		385, 387	0	
42.00	Balance due provider/program (line 40 minus line 41)		-37, 593	0	
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				l

Health Financial Systems

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

Provi der CCN: 15-0030

Peri od: Worksheet G From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 2/15/2017 2:11 pm

				I	2/15/2017 2:1	1 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1 00	Purpose Fund	2 00	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1. 00	Cash on hand in banks	7, 785, 833		0	0	1.00
2. 00	Temporary investments	7,703,033			0	
3.00	Notes recei vabl e	0		, i	0	
4. 00	Accounts receivable	9, 822, 764			0	
5. 00	Other receivable	0	1	0	Ō	
6. 00	Allowances for uncollectible notes and accounts receivable	0	1	o o	0	6. 00
7. 00	Inventory	0		0	0	
8. 00	Prepai d expenses	23, 213	1	0	0	8. 00
9.00	Other current assets	3, 189, 763		o	0	9. 00
10.00	Due from other funds	72, 364, 988		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	93, 186, 561	(	0	0	11. 00
	FIXED ASSETS		<u>'</u>	<u> </u>		
12.00	Land	46, 000	(	0	0	12. 00
13.00	Land improvements	1, 621, 597	(	o	0	13. 00
14.00	Accumulated depreciation	-1, 590, 091		o	0	14. 00
15.00	Bui I di ngs	36, 516, 120	(	0	0	15. 00
16.00	Accumul ated depreciation	-29, 900, 353	(	0	0	16. 00
17.00	Leasehold improvements	2, 434, 464	(	0	0	17. 00
18. 00	Accumul ated depreciation	-1, 178, 329	(	0	0	18. 00
19. 00	Fi xed equipment	15, 789, 321	(	0	0	19. 00
20.00	Accumul ated depreciation	-14, 189, 462	(	0	0	20. 00
21. 00	Automobiles and trucks	0	(	0	0	21. 00
22. 00	Accumulated depreciation	0	(	0	0	22. 00
23. 00	Major movable equipment	40, 870, 878	(	0	0	23. 00
24. 00	Accumulated depreciation	-27, 164, 897	(	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	(	0	0	25. 00
26. 00	Accumul ated depreciation	0	(	0	0	26. 00
27. 00	HIT designated Assets	0	C	0	0	27. 00
28. 00	Accumulated depreciation	0	C	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	C		0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	23, 255, 248	(	0	0	30.00
	OTHER ASSETS	_	1	_	_	
31. 00	Investments	0	C		0	31.00
32. 00	Deposits on Leases	0	(	0	0	32.00
33. 00	Due from owners/officers	0		0	0	33. 00
34.00	Other assets	21, 151, 329		0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	21, 151, 329			0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	137, 593, 138		0	0	36. 00
27.00	CURRENT LIABILITIES	27 0/2 712	1	) 0	0	27.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	27, 962, 713		-	0	37. 00 38. 00
39. 00	Payrol I taxes payable	4, 217, 416			0	39.00
40. 00	Notes and Loans payable (short term)	0			0	40.00
41. 00	Deferred income	0			0	41.00
42. 00	Accel erated payments	0			U	42.00
43. 00	Due to other funds	0	,		0	
44. 00	Other current liabilities	2, 929, 295			0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	35, 109, 424	1		_	
10.00	LONG TERM LIABILITIES	00, 107, 121		)  0	<u> </u>	10.00
46. 00	Mortgage payable	0	(	0	0	46. 00
47. 00	Notes payable	0		-	0	47. 00
48. 00	Unsecured Loans	0			0	
49. 00	Other long term liabilities	16, 328, 649		-	0	1
50. 00	Total long term liabilities (sum of lines 46 thru 49)	16, 328, 649			0	
51. 00	Total liabilities (sum of lines 45 and 50)	51, 438, 073		o o		51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	86, 155, 065				52. 00
53.00	Specific purpose fund		1 0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	
	repl acement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	86, 155, 065	•	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	137, 593, 138	C	0	0	60.00
	[59]		l			İ

In Lieu of Form CMS-2552-10 Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0030 Peri od: Worksheet G-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 2/15/2017 2:11 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 80, 047, 495 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 6, 107, 571 2.00 3.00 Total (sum of line 1 and line 2) 86, 155, 066 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 86, 155, 066 0 11.00 11.00 12.00 MI SC 0 12.00 13.00 0000 13.00 14.00 0 14.00 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 86, 155, 065 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 0 0 11.00 Subtotal (line 3 plus line 10) 11.00 12.00 MI SC 12.00

0

0

0

0

0

13.00

14.00

15.00

16.00

17.00

18.00

19.00

13.00

14.00

15.00

16.00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

 
 Heal th Financial Systems
 HEN

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN: 15-0030

			10		2/15/2017 2:1	
	Cost Center Description	Lnn	ati ent	Outpati ent	Total	рш
	oost contor bescriptron		. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES		. 00	2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal	10	), 164, 421		10, 164, 421	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF		0		o	3.00
4.00	SUBPROVI DER		0		0	4.00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	10	), 164, 421		10, 164, 421	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4	, 472, 272		4, 472, 272	11. 00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)		470 070		4 470 070	15.00
16. 00	Total intensive care type inpatient hospital services (sum of	lines 4	, 472, 272		4, 472, 272	16. 00
17. 00	11-15)  Total inpatient routine care services (sum of lines 10 and 16)	1.4	424 402		14 (24 (02	17. 00
18.00	Ancillary services		, 636, 693 3, 032, 908	105 175 700	14, 636, 693 153, 208, 706	17.00
19.00	Outpatient services		, 257, 629	105, 175, 798 13, 191, 264	14, 448, 893	19. 00
20.00	RURAL HEALTH CLINIC	'	, 237, 629	13, 191, 204	14, 446, 693	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		O	2, 080, 149	2, 080, 149	22. 00
23. 00	AMBULANCE SERVICES			2,000,147	2,000,149	23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )					25. 00
26. 00	HOSPI CE		0	2, 090, 475	2, 090, 475	26. 00
27. 00	NURSERY		770, 846	2,070,170	770, 846	27. 00
27. 01	PRO FEES		4, 484	7, 076, 318	7, 080, 802	27. 01
27. 02	OTHER		458	7, 625	8, 083	27. 02
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst. 64	, 703, 018	129, 621, 629	194, 324, 647	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			76, 521, 304		29.00
30.00	ADD (SPECIFY)		0			30.00
31. 00			0			31.00
32. 00			0			32.00
33. 00			0			33.00
34. 00			0			34.00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		_	0		36. 00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38. 00			0			38. 00
39. 00			0			39. 00
40.00			0			40.00
41.00	Total deductions (sum of lines 27 41)		U			41. 00 42. 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		76, 521, 304		42.00
43.00	to Wkst. G-3, line 4)	) (Li alisi ei		70, 321, 304		43.00
	10 mcst. 0 0, 11110 4)	I		ı	ı	

	Financial Systems HENRY COUNTY MENT OF REVENUES AND EXPENSES	MEMORIAL HOSPITAL Provider CCN: 15-0030	Peri od:	u of Form CMS-2 Worksheet G-3	
			From 01/01/2015		
			To 12/31/2015	Date/Time Prep 2/15/2017 2:1	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3,			194, 324, 647	
2.00	Less contractual allowances and discounts on patients' ad	ccounts		116, 929, 434	
3.00	Net patient revenues (line 1 minus line 2)			77, 395, 213	
4. 00	Less total operating expenses (from Wkst. G-2, Part II,			76, 521, 304	
5.00	Net income from service to patients (line 3 minus line 4)	)		873, 909	5.00
/ 00	OTHER I NCOME			0	/ 00
6. 00 7. 00	Contributions, donations, bequests, etc Income from investments			0	
7. 00 8. 00	Revenues from telephone and other miscellaneous communications	ation convious		0	
9.00	Revenue from television and radio service	ation services		0	
10.00	Purchase di scounts			0	1
11. 00	Rebates and refunds of expenses			0	
12. 00	Parking Lot receipts			0	
13. 00	Revenue from Laundry and Linen service			0	1
14. 00	Revenue from meals sold to employees and guests			0	
15. 00	Revenue from rental of living quarters			0	
16. 00	Revenue from sale of medical and surgical supplies to other	her than patients		0	
17. 00	Revenue from sale of drugs to other than patients	разгана		0	1
18. 00	Revenue from sale of medical records and abstracts			0	1
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	HOSPITAL OTHER REVENUE			4, 830, 267	24. 00
24. 01	HOSPITAL NON OPERATING INCOME			206, 505	24. 01
24. 02	CATH LAB INTEREST INCOME			497	
24. 04	NCFIM- OTHER INCOME			417, 823	
24. 05	NCFIM- OTHER NONOPERATING REVENUE			51, 330	
	,			5, 506, 422	
	Total (line 5 plus line 25)			6, 380, 331	
27 00	HOSPITAL OTHER EXPENSE			272 760	1 27 00

272, 760 27. 00 272, 760 28. 00 6, 107, 571 29. 00

27. 00 HOSPITAL OTHER EXPENSE

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)

0

0

0

0

0

1, 186, 370

Ω

3.047

0

O

0

1, 189, 417

22.00

23.00

23.50

24.00

Homemaker Service

Tel emedi ci ne

All Others (specify)

24.00 Total (sum of lines 1-23)

22.00

23.00

23. 50

	<u>Financial Systems</u> LLOCATION - HHA GENERAL SERVICE		NRY COUNTY MEMO	Provider C		Peri od:	u of Form CMS-2 Worksheet H-1	
				HHA CCN:	15-7430	From 01/01/2015 To 12/31/2015	Part I Date/Time Pre 2/15/2017 2:1	pared
						Home Health	PPS	ı pııı
			Capital Rela	ited Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H,	Bl dgs & Fi xtures	Movabl e Equi pment	Plant Operation & Maintenance		Subtotal (cols. 0-4)	
		col . 10)					44.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3. 00	4. 00	4A. 00	
00	Capital Related - Bldg. &	0	0				0	1. (
00	Fixtures Capital Related - Movable	0		0			0	2. (
	Equi pment			· ·			_	-
00 00	Plant Operation & Maintenance Transportation	0	0	0		0 0	0	3. 4.
00	Administrative and General	353, 673	0	0		0 0	353, 673	
00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	400 044	O	0	I		400 044	,
00 00	Physical Therapy	490, 944 233, 730	0	0		0 0	490, 944 233, 730	1
00	Occupational Therapy	85, 736	0	0		0 0	85, 736	8.
00	Speech Pathology Medical Social Services	184 0	0	0		0 0	184 0	1
. 00	Home Heal th Aide	25, 150	0	0		0 0	25, 150	
. 00	Supplies (see instructions)	0	0	0		0 0	0	
. 00	Drugs DME	0	0	0		0 0	0	
. 00	HHA NONREI MBURSABLE SERVI CES	0	<u> </u>	0		0	J	'¬.
. 00	Home Dialysis Aide Services	0	0	0		0 0	0	
. 00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	
. 00	Clinic	Ö	Ö	Ö		0 0	0	1 .
. 00	Health Promotion Activities	0	0	0		0 0	0	1
. 00	Day Care Program Home Delivered Meals Program	0	0	0			0	
. 00	Homemaker Service	0	O	0		0 0	0	22.
. 00	All Others (specify) Telemedicine	0	0	0		0 0	0	
. 50 . 00	Total (sum of lines 1-23)	1, 189, 417	0	0		0 0	0 1, 189, 417	
		Admi ni strati ve						
		& General 5.00	4A + 5) 6.00					1
	GENERAL SERVICE COST CENTERS	0.00	0.00					
00	Capital Related - Bldg. &   Fixtures							1.
00	Capital Related - Movable							2.
20	Equi pment							1
00 00	Plant Operation & Maintenance Transportation							4.
00	Administrative and General	353, 673						5.
00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	207, 759	698, 703					6.
00	Physical Therapy	98, 911	332, 641					7.
00	Occupational Therapy	36, 282	122, 018					8.
00	Speech Pathology Medical Social Services	78 0	262 0					10
00	Home Health Aide	10, 643	35, 793					11.
. 00	Supplies (see instructions)	0	0					12
. 00	Drugs DME	0	0					13. 14.
	HHA NONREIMBURSABLE SERVICES							
. 00	Home Dialysis Aide Services Respiratory Therapy	0	0					15. 16.
	Private Duty Nursing	0	0					17.
. 00	Clinic	0	0					18.
. 00	1	0	0					19.
. 00	9	0	0					20.
	1	O	O					22.
. 00								
. 00	All Others (specify) Telemedicine	0	0					23. 23.

	Financial Systems LLOCATION - HHA STATISTICAL BAS		ENRY COUNTY MEN	Provider Co		Peri od: From 01/01/2015 To 12/31/2015		pared:
						Home Health Agency I	PPS	
		Capital Rel	ated Costs			Agency		
		, ,	Movable Equipment (DOLLAR VALUE)	Pl ant Operation & Mai ntenance (SQUARE FEET)	(MI LEAGE)	onReconciliation	& General (ACCUM. COST)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5A. 00	5. 00	
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment Plant Operation & Maintenance	0	0	0		0		2.00
4.00	Transportation (see instructions)	0	0	0		0		4. 00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	0	0	0		0 -353, 673	835, 744	5. 00
6.00	Skilled Nursing Care	0	0	0	1	0 0	490, 944	
7.00	Physical Therapy	0	0	0	1	0 0	233, 730	
8. 00 9. 00	Occupational Therapy Speech Pathology	0	0	0		0 0	85, 736 184	1
10.00	Medical Social Services	0	0	0			104	10.00
11. 00	Home Health Aide	0	0	0		0	25, 150	
12. 00	Supplies (see instructions)	0	0	0		0 0	25, 150	1
13. 00	Drugs	Ö	o o	Ö		0	0	
14.00	DME	Ō	0	0	)	0 0	0	14.00
	HHA NONREIMBURSABLE SERVICES		T					
	Home Dialysis Aide Services	0	0		l .	0	0	
16. 00	Respiratory Therapy	0	0	0	l .	0	0	
17. 00	Private Duty Nursing	0	0	0	1	0 0	0	
18. 00	Clinic	0	0	0	1	0 0	0	
19.00	Health Promotion Activities	0	0	0	1	0 0	0	
20.00	Day Care Program	0	0	0	1	0 0	0	1 20.00
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0	0	l .	0 0	0	21. 00 22. 00
23. 00	All Others (specify)	0	0			0 0	0	
23. 50	Telemedicine		0	0		0 0	0	23. 50
24. 00	Total (sum of lines 1-23)	0	0	0		0 -353, 673	835, 744	
25. 00	Cost To Be Allocated (per Worksheet H-1, Part I)	ő	Ö	0	1	0	353, 673	
26 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 00000	00	0. 423183	26. 00

HEARY ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Peri od: Worksheet H-2
From 01/01/2015 Part I
To 12/31/2015 Date/Ti me Prepared: 2/15/2017 2:11 pm Provi der CCN: 15-0030 HHA CCN: 15-7430 Home Health PPS

						Home Health Agency I	PPS	
			CAPITAL REL	ATED COSTS		Agency i		
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & 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 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 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	0 698, 703 332, 641 122, 018 262 0 35, 793 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	2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00 268, 757 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	268, 757 698, 703 332, 641 122, 018 262 0 35, 793 0 0 0 0 0 0 0 1, 458, 174 0. 0000000	63, 857 166, 015 79, 036 28, 992 62 0 8, 505 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 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 50 20. 00 21. 00
	of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.  Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	
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 19. 00 20. 00 21. 00	Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 11,884 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00

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

неат т	n Financiai Systems	HE	NRY COUNTY MEMO	JRIAL HUSPITAL		In Lie	eu or Form CMS-2	2552-10
ALLOC	ATION OF GENERAL SERVICE COSTS 1	TO HHA COST CENT	TERS	Provider CO	CN: 15-0030 15-7430	Peri od: From 01/01/2015 To 12/31/2015		pared:
						Home Health	PPS	<u>ı pııı</u>
	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	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	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)	4, 572 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	10, 881 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	359, 9 864, 7 411, 6 151, 0	51 0 18 0 77 0 10 0 24 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	359, 951 864, 718 411, 677 151, 010 324 0 44, 298 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. 00
	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	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)	27. 00  211, 448 100, 666 36, 926 79 0 10, 832 0 0 0 0 0 0 0 0 0 0 0 359, 951 0. 244527	28. 00  1, 076, 166 512, 343 187, 936 403 0 55, 130 0 0 0 0 0 0 0 0 0 1, 831, 978					1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 00 20. 00 21. 00

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

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS		Period: Worksheet H-2 From 01/01/2015 Part II
BAST S		To 12/31/2015 Date/Time Prepared:

2/15/2017 2:11 pm

Home Health Agency I CAPITAL RELATED COSTS NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliation ADMINISTRATIVE OPERATION OF Cost Center Description FLXT **FOULP BENEFITS** & GENERAL PI ANT (SQUARE (SQUARE **DEPARTMENT** (ACCUM. (SQUARE FEET) FEET) (GROSS COST) FEET) SALARI ES) 1.00 2.00 7.00 5A 5.00 4.00 0 1.00 Administrative and General 0 946, 665 0 268.757 1.00 0 2.00 Skilled Nursing Care 0 698, 703 2.00 3.00 Physical Therapy 0 0 332, 641 3.00 000000000000 Occupational Therapy 0 122, 018 4.00 0 0 0 4.00 0 0 5.00 Speech Pathology 262 5.00 6.00 Medical Social Services 0 0 0 6.00 0 7.00 Home Health Aide 0 35, 793 7.00 0 0 0 8.00 8.00 Supplies (see instructions) 0 0 9.00 Drugs C 0 0 9.00 10.00 DMF 0 0 10.00 0 0 11.00 Home Dialysis Aide Services 0 0 11.00 0 0 12.00 Respiratory Therapy 0 12.00 13.00 Private Duty Nursing 0 13.00 0 0000000 0 14.00 Clinic 0 0 0 14.00 0 0 Health Promotion Activities 15.00 C 15.00 16.00 Day Care Program C 16.00 17.00 Home Delivered Meals Program 0 0 17.00 0 0 0 Homemaker Service 18.00 18.00 0 C 0 19.00 All Others (specify) 19.00 19.50 Tel emedi ci ne 0 0 19.50 Total (sum of lines 1-19) 0 20.00 946, 665 1, 458, 174 20.00 21.00 Total cost to be allocated 268. 757 346, 467 21.00 0.000000 0. 283899 0. 237603 0.000000 22.00 Unit cost multiplier 0.000000 22.00 Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL LINEN SERVICE (HOURS OF (PATI ENT (FTE'S) ADMINI STRATION SERVICES & (POUNDS OF SERVICE) DAYS) **SUPPLY** LAUNDRY) (COSTED (DI RECT NRSING HRS) REQUIS.) 8.00 9.00 10.00 11.00 13.00 14.00 1.00 Administrative and General 55 19, 931 1. 00 0 2.00 Skilled Nursing Care 0 0 0 0 0 0 0 0 0 0 2.00 000000000000000000 0 0 3 00 Physical Therapy 3 00 O 0 4.00 Occupational Therapy 0 0 4.00 5.00 Speech Pathology 0 0 0 5.00 0 0 6 00 Medical Social Services 0 6 00 O 0 7.00 Home Heal th Aide 0 7.00 8.00 Supplies (see instructions) 0 0 0 8.00 Drugs 0 0 9.00 0 0 0 0 0 0 0 0 0 0 9.00 0 0 10 00 10.00 DMF Ω Home Dialysis Aide Services 11.00 0 11.00 Respiratory Therapy 0 0 12.00 12.00 13.00 Private Duty Nursing 0 0 0 0 0 13.00 0 14.00 0 14.00 Clinic 15.00 Health Promotion Activities 0 0 15.00 Day Care Program 16.00 16.00 0 0 0 0 0 17.00 Home Delivered Meals Program 17.00 0 18.00 Homemaker Service C 18.00 0 19.00 All Others (specify) 0 0 19.00 19.50 Tel emedi ci ne 0 0 C 0 0 19.50 Total (sum of lines 1-19) 0 19.931 20.00 20.00 55 0 0 C 21.00 Total cost to be allocated Ω 11.884 4, 572 21.00

216. 072727

0.000000

0.000000

0.000000

0. 229391

22.00

0. 000000

Unit cost multiplier

22.00

	Financial Systems TION OF GENERAL SERVICE COSTS T		NRY COUNTY MEMOR	Provider CCN:	1F 0020	In Lie	u of Form CMS-	
	TITON OF GENERAL SERVICE COSTS I	O HHA COST CENT	ERS STATESTICAL	Provider CCN:	15-0030	From 01/01/2015	Worksheet H-2 Part II	
BASIS				HHA CCN:	15-7430	To 12/31/2015		pared:
							2/15/2017 2:1	
						Home Health	PPS	
						Agency I		
	Cost Center Description	PHARMACY	MEDI CAL					
		(COSTED	RECORDS &					
		REQUIS.)	LIBRARY					
			(TIME					
		15. 00	SPENT) 16. 00					-
1. 00	Administrative and General	15.00	16.00					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	Speech Pathology	0	0					5. 00
6.00	Medical Social Services	0	0					6.00
7. 00	Home Health Aide	0	0					7. 00
8.00	Supplies (see instructions)	0	0					8.00
9. 00	Drugs	0	0					9. 00
10.00	DME	0	0					10.00
11. 00	Home Dialysis Aide Services	0	o					11. 00
12.00	Respiratory Therapy	0	O					12. 00
13.00	Private Duty Nursing	0	o					13. 00
14.00	Clinic	0	o					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	0					17. 00
18. 00	Homemaker Service	0	0					18. 00
19. 00	All Others (specify)	0	0					19. 00
19. 50	Tel emedi ci ne	0	0					19. 50
20.00	Total (sum of lines 1-19)	0	16					20. 00
21.00	Total cost to be allocated	0	10, 881					21. 00
22.00	Unit cost multiplier	0. 000000	680. 062500					22. 00

Heal th	Financial Systems	нг	ENRY COUNTY MEMO	NELDENH IN INC		Inlie	u of Form CMS-2	2552_10
	TIONMENT OF PATIENT SERVICE COST		LINKT COONTT INCIN		CN: 15-0030	Peri od:	Worksheet H-3	.552 10
				HHA CCN:		From 01/01/2015 To 12/31/2015	Part I	
				Ti tl e	e XVIII	Home Health Agency I	PPS	•
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
		0	1.00	Part II) 2.00	3.00	4. 00	4) 5. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION	OI AGGREGATE F	-ROGRAW COST, A	JUNEUATE OF TE	IL FROGRAM LIM	TIATION COST, OF	`	
	Cost Per Visit Computation	1	1 2 22 4 4 1		1		252 (2	
1.00	Skilled Nursing Care	2.00			1, 076, 16			1.00
2.00	Physical Therapy	3.00		C			186. 85	
3.00	Occupational Therapy	4.00	1	C			253. 97	3.00
4. 00 5. 00	Speech Pathology Medical Social Services	5. 00 6. 00	1	C	1	35	11. 51 0. 00	4. 00 5. 00
6. 00	Home Heal th Aide	7. 00	1		55, 13	-	66. 10	
7. 00	Total (sum of lines 1-6)	7.00	1, 831, 978	C	1			7. 00
7.00	Total (Suil of Titles 1-0)		1,031,770		Program Visit			7.00
						ırt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t	_		
	oost denter beserretron	oost Ermits	020/1 110. (1)	rui t 7t	Deducti bl es			
					Coi nsurance			
		0	1.00	2.00	3.00	4. 00	5. 00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		34620	C	1	2		8.00
8. 01	Skilled Nursing Care		50031	C	2, 37	8		8. 01
8. 02	Skilled Nursing Care		99915	C		5		8. 02
9.00	Physical Therapy		34620	C		8		9. 00
9. 01	Physi cal Therapy		50031	C	1, 92			9. 01
9. 02	Physi cal Therapy	1	99915	C		0		9. 02
10.00	Occupational Therapy		34620	C		0		10.00
10. 01	Occupational Therapy		50031	C				10. 01
10. 02	Occupational Therapy		99915	C		0		10. 02
11.00	Speech Pathology		34620	C		0		11.00
11. 01	Speech Pathology		50031 99915	C		1		11. 01
11. 02	Speech Pathology		1	C		0		11. 02
12.00	Medical Social Services Medical Social Services	•	34620 50031	C		0		12. 00 12. 01
12. 01 12. 02	Medical Social Services		99915			0		12. 01
13. 00	Home Heal th Aide		34620			0		13. 00
13. 00	Home Health Aide		50031	C	51			13. 00
13. 01			99915	C	1	0		13. 01
	Total (sum of lines 8-13)		77713	C		0		14. 00
14.00	Cost Center Description	From Wkst H_2	Facility Costs	Shared	Total HHA		Ratio (col. 3	14.00
	cost center bescription	Part I, col.	(from Wkst.		Costs (col s.	1 (from HHA	÷ col . 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)	. 661. 1)	
				Part II)	<b>'</b>			
		0	1.00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Computa							
15. 00		8. 00		C		0	0. 000000	
16. 00	Cost of Drugs	9. 00		C		0 0	0. 000000	16. 00
			Program Visits		Cost of			
					Servi ces	2 . 2		
	0 1 0 1 0 1 1		Par		٠	Part B	0.11	
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles & Coinsurance	Coi nsurance		Deductibles & Coinsurance	Deductibles & Coinsurance	
		6.00	7. 00	8. 00	9. 00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER							
		S. MOSINEOMIL I		JONEON E OF T	TROOMAIN ETIM	0031, 01	`	
	BENEFICIARY COST LIMITATION							
1, 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation	0	2, 395			0 600, 235		1, 00
1. 00	BENEFICIARY COST LIMITATION	0 0	1			0 600, 235 0 361, 368		1. 00 2. 00
	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	1						
2.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	1	1, 934 561			0 361, 368		2. 00
2. 00 3. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	0	1, 934 561			0 361, 368 0 142, 477		2. 00 3. 00
2.00 3.00 4.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0	1, 934 561 41 0			0 361, 368 0 142, 477 0 472		2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0 0 0 0	1, 934 561 41 0 519			0 361, 368 0 142, 477 0 472 0 0		2. 00 3. 00 4. 00 5. 00

	Financial Systems  IONMENT OF PATIENT SERVICE COST		ENRY COUNTY MEM	Provider CO		Peri od: From 01/01/2015 To 12/31/2015 Home Heal th Agency I	Worksheet H-3 Part I Date/Time Pre 2/15/2017 2:1 PPS	epared:
	Cost Center Description	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
0.00	Limitation Cost Computation	Г			T			0.00
8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)	Drog	rom Coupered Chr		Contract			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
		Prog	ram Covered Cha	irges	Cost of Services			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance 7.00	Subject to	Part A	Part B Not Subject to Deductibles & Coinsurance 10.00	Subject to Deductibles & Coinsurance 11.00	
	Supplies and Drugs Cost Computa	ati ons						
15. 00 16. 00	Cost of Medical Supplies Cost of Drugs	0	0		1	0 0		
	Cost Center Description  PART I - COMPUTATION OF LESSER	Total Program Cost (sum of cols. 9-10) 12.00 OF AGGREGATE F	-	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	₹	
	BENEFICIARY COST LIMITATION							-
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	600, 235 361, 368 142, 477 472 0 34, 306 1, 138, 858						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
	Cost Center Description	12. 00						
12. 01 12. 02 13. 00 13. 01 13. 02	Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide	12.00						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

Heal th	Financial Systems	HE	ENRY COUNTY MEM	ORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10	
APP0RT	IONMENT OF PATIENT SERVICE COST	S		Provi der C		Peri od: From 01/01/2015	Worksheet H-3 Part II	
				HHA CCN:	15-7430	To 12/31/2015		
				Title	XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3.00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIO	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physi cal Therapy	66. 00	0. 656274	0		0 col. 2, line 2	. 00	1. 00
2.00	Occupational Therapy							2. 00
3.00	Speech Pathology	68. 00	0. 872761	0	)	0 col. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71. 00	0. 111132	0	)	0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73. 00	0. 166420	0	)	0 col. 2, line 1	6. 00	5. 00

- COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOBLE COST of Part A & Part B Services ble Cost of Part A & Part B Services ble cost of services (see instructions) charges ry Charges actually collected from patients liable for payment fo large basis (from your records) that would have been realized from patients liable for rvices on a charge basis had such payment been made in a CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost filine 6 exceeds line 1) of reasonable cost over customary charges (complete on loss line 6) r payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT reasonable cost (see instructions)	r services payment accordance (complete	15-7430 XVIII Part A	Not Subject 1 Deductibles Coinsurance 2.00	Date/Time Pre   2/15/2017 2:1   PPS	00 1111 pl
ble Cost of Part A & Part B Services  able cost of services (see instructions)  charges  ry Charges  actually collected from patients liable for payment for large basis (from your records)  that would have been realized from patients liable for vices on a charge basis had such payment been made in a CFR §413.13(b)  of line 3 to line 4 (not to exceed 1.000000)  customary charges (see instructions)  of total customary charges over total reasonable cost  filine 6 exceeds line 1)  of reasonable cost over customary charges (complete on lads line 6)  ry payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT  reasonable cost (see instructions)	DMARY CHARGES  r services  payment accordance  (complete	Part A 1.00	Agency I Property I Not Subject 1 Deductibles Coinsurance 2.00  0 0 0 0 0 Part A Services	PPS   PPS	30
ble Cost of Part A & Part B Services  able cost of services (see instructions)  charges  ry Charges  actually collected from patients liable for payment for large basis (from your records)  that would have been realized from patients liable for vices on a charge basis had such payment been made in a CFR §413.13(b)  of line 3 to line 4 (not to exceed 1.000000)  customary charges (see instructions)  of total customary charges over total reasonable cost  filine 6 exceeds line 1)  of reasonable cost over customary charges (complete on lads line 6)  ry payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT  reasonable cost (see instructions)	r services payment accordance (complete	1.00	Not Subject to Deductibles Coinsurance 2.00	Subject to   Deductibles & Coinsurance   3.00   0   0   0   0   0   0   0   0   0	100 110 100 100 100 100 100 100 100 100
ble Cost of Part A & Part B Services  able cost of services (see instructions)  charges  ry Charges  actually collected from patients liable for payment for large basis (from your records)  that would have been realized from patients liable for vices on a charge basis had such payment been made in a CFR §413.13(b)  of line 3 to line 4 (not to exceed 1.000000)  customary charges (see instructions)  of total customary charges over total reasonable cost  filine 6 exceeds line 1)  of reasonable cost over customary charges (complete on lads line 6)  ry payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT  reasonable cost (see instructions)	r services payment accordance (complete	1.00	Not Subject 1 Deductibles Coinsurance 2.00  0 0 0 0 0 0 Part A Services	Subject to   Deductibles & Coinsurance   3.00   0   0   0   0   0   0   0   0   0	100 110 100 100 100 100 100 100 100 100
ble Cost of Part A & Part B Services  able cost of services (see instructions)  charges  ry Charges  actually collected from patients liable for payment for large basis (from your records)  that would have been realized from patients liable for vices on a charge basis had such payment been made in a CFR §413.13(b)  of line 3 to line 4 (not to exceed 1.000000)  customary charges (see instructions)  of total customary charges over total reasonable cost  filine 6 exceeds line 1)  of reasonable cost over customary charges (complete on lads line 6)  ry payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT  reasonable cost (see instructions)	r services payment accordance (complete		Coi nsurance   2.00	Coi nsurance   3.00   0   0   0   0   0   0   0   0   0	100 110 100 100 100 100 100 100 100 100
ble Cost of Part A & Part B Services  able cost of services (see instructions)  charges  ry Charges  actually collected from patients liable for payment for large basis (from your records)  that would have been realized from patients liable for vices on a charge basis had such payment been made in a CFR §413.13(b)  of line 3 to line 4 (not to exceed 1.000000)  customary charges (see instructions)  of total customary charges over total reasonable cost  filine 6 exceeds line 1)  of reasonable cost over customary charges (complete on lads line 6)  ry payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT  reasonable cost (see instructions)	r services payment accordance (complete		2.00  0 0 0 0 0 0 0 0 0 0 Part A Services	3.00  0 0 0  0 0  0 0  0 0  0 0  0 0  0	2 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3
ble Cost of Part A & Part B Services  able cost of services (see instructions)  charges  ry Charges  actually collected from patients liable for payment for large basis (from your records)  that would have been realized from patients liable for vices on a charge basis had such payment been made in a CFR §413.13(b)  of line 3 to line 4 (not to exceed 1.000000)  customary charges (see instructions)  of total customary charges over total reasonable cost  filine 6 exceeds line 1)  of reasonable cost over customary charges (complete on lads line 6)  ry payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT  reasonable cost (see instructions)	r services payment accordance (complete		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	2 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3
ble Cost of Part A & Part B Services  able cost of services (see instructions)  charges  ry Charges  actually collected from patients liable for payment for large basis (from your records)  that would have been realized from patients liable for vices on a charge basis had such payment been made in a CFR §413.13(b)  of line 3 to line 4 (not to exceed 1.000000)  customary charges (see instructions)  of total customary charges over total reasonable cost  filine 6 exceeds line 1)  of reasonable cost over customary charges (complete on lads line 6)  ry payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT  reasonable cost (see instructions)	r services payment accordance (complete		0 0 0 0.00000 0 0 0.00000 0 0 0 Part A Services	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3
ble cost of services (see instructions) charges ry Charges actually collected from patients liable for payment for large basis (from your records) that would have been realized from patients liable for vices on a charge basis had such payment been made in a CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost filine 6 exceeds line 1) of reasonable cost over customary charges (complete on last line 6) or payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT reasonable cost (see instructions)	payment accordance (complete	0.0000	0 0 0 0.00000 0 0 0.00000 0 0 0 Part A Services	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3
charges ry Charges actually collected from patients liable for payment for partial par	payment accordance (complete	0.0000	0 0 0 0.00000 0 0 0.00000 0 0 0 Part A Services	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3
actually collected from patients liable for payment fo large basis (from your records) that would have been realized from patients liable for rivices on a charge basis had such payment been made in a CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) sustomary charges (see instructions) of total customary charges over total reasonable cost cost ine 6 exceeds line 1) of reasonable cost over customary charges (complete on line 6) or payer amounts	payment accordance (complete	0.0000	0 0 0.00000 0 0 0.00000 0 0 0 0 Part A Services	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	500 3 500 6 600 6 700 7 800 9
actually collected from patients liable for payment for large basis (from your records) that would have been realized from patients liable for vices on a charge basis had such payment been made in 2 CFR \$413.13(b) of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost fline 6 exceeds line 1) of reasonable cost over customary charges (complete on eds line 6) or payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT reasonable cost (see instructions)	payment accordance (complete	0.0000	000 0.00000 0 0 0 0 0 Part A Services	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	500 4 500 6 600 7 7 8 8 9 9
that would have been realized from patients liable for rotices on a charge basis had such payment been made in a CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost line 6 exceeds line 1) of reasonable cost over customary charges (complete on eds line 6) or payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT reasonable cost (see instructions)	payment accordance (complete	0.0000	000 0.00000 0 0 0 0 0 Part A Services	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50 4 50 5 50 6 7 7 8 8 8 9 9 10 10 10 10 10 10 10 10 10 10 10 10 10
that would have been realized from patients liable for vices on a charge basis had such payment been made in 2 CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) sustomary charges (see instructions) of total customary charges over total reasonable cost fline 6 exceeds line 1) of reasonable cost over customary charges (complete on sids line 6) or payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT reasonable cost (see instructions)	accordance (complete	0.0000	000 0.00000 0 0 0 Part A Services	00 0.000000 0 0 0 0 0 0 0 Part B Services 2.00	) 5 ) 6 ) 7 ) 8 ) 9 ) 10
vices on a charge basis had such payment been made in a CFR §413.13(b)  of line 3 to line 4 (not to exceed 1.000000)  customary charges (see instructions) of total customary charges over total reasonable cost line 6 exceeds line 1) of reasonable cost over customary charges (complete on eds line 6) or payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT reasonable cost (see instructions)	accordance (complete	0.0000	000 0.00000 0 0 0 Part A Services	00 0.000000 0 0 0 0 0 0 0 Part B Services 2.00	50 66 70 7 80 8 90 9
2 CFR §413.13(b) 2 CFR §413.13(b) 3 of line 3 to line 4 (not to exceed 1.000000) 3 customary charges (see instructions) 4 of total customary charges over total reasonable cost 5 line 6 exceeds line 1) 5 of reasonable cost over customary charges (complete on eds line 6) 6 payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT 5 ceasonable cost (see instructions)	(complete	0.0000	0 0 0 Part A Services	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	) 6 7 8 9 10 9 11
of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost line 6 exceeds line 1) of reasonable cost over customary charges (complete on eds line 6) y payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT reasonable cost (see instructions)	` '	0.0000	0 0 0 Part A Services	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0) 6
customary charges (see instructions) of total customary charges over total reasonable cost fline 6 exceeds line 1) of reasonable cost over customary charges (complete on eds line 6) payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT reasonable cost (see instructions)	` '		0 0 0 Part A Services	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0) 6
of total customary charges over total reasonable cost line 6 exceeds line 1) of reasonable cost over customary charges (complete on eds line 6) payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT reasonable cost (see instructions)	` '		0 0 Part A Services	0 0 0 0 0 Part B Services 2.00 0 0	0) 8
of reasonable cost over customary charges (complete on eds line 6) payer amounts  - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT reasonable cost (see instructions)	y if line		Part A Services	0	0 10
- COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT reasonable cost (see instructions)	ly if line		Part A Services	0	0 10
- COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT reasonable cost (see instructions)			Part A Services	Part B Services 2.00	0 10
- COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT reasonable cost (see instructions)			Part A Services	Part B Services 2.00	0 10
reasonable cost (see instructions)			Servi ces	Services 2.00 0	11
reasonable cost (see instructions)				2.00	11
reasonable cost (see instructions)			1.00	0 0	11
· · · · · · · · · · · · · · · · · · ·					11
NDC Daimburgament - Full Enisses				0 852, 319	
PPS Reimbursement - Full Episodes without Outliers					
PPS Reimbursement - Full Episodes with Outliers				0 18, 414	1 12
PPS Reimbursement – LUPA Episodes				0 8, 835	
PPS Reimbursement - PEP Episodes				0 7, 820	
PPS Outlier Reimbursement - Full Episodes with Outliers				0 3, 115	
PPS Outlier Reimbursement - PEP Episodes				0 1	
Other Payments				0 0	
ments				0 0	
Payments				0 0	
etic and Orthotic Payments	`			0	
deductibles billed to Medicare patients (exclude coins	urance)			0	
II (sum of lines 10 thru 20 minus line 21)				0 890, 504	
reasonable cost (from line 8) Il (line 22 minus line 23)				0 890 504	
rance billed to program patients (from your records)				0 890, 504	
it (line 24 minus line 25)				0 890, 504	
· · · · · · · · · · · · · · · · · · ·				0 690, 304	27
	netructione)				28
				0 890 504	
	3 21)				
, , ,	5)				
	-,				
d (see instructions)					
l (see instructions) ration adjustment (see instructions)				•	
ration adjustment (see instructions)				0 0/2,0/4	
ration adjustment (see instructions) n payments (see instructions)				0 0	
ration adjustment (see instructions) n payments (see instructions) ve settlement (for contractor use only)	and 33)			-1	)  34
	osts - current cost reporting period (line 26 plus line DJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ACO demonstration payment adjustment (see instructions (see instructions)	sable bad debts for dual eligible beneficiaries (see instructions) osts - current cost reporting period (line 26 plus line 27) DJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ACO demonstration payment adjustment (see instructions) (see instructions) ration adjustment (see instructions)	sable bad debts for dual eligible beneficiaries (see instructions) ssts - current cost reporting period (line 26 plus line 27) DJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ACO demonstration payment adjustment (see instructions) (see instructions) ration adjustment (see instructions) payments (see instructions)	sable bad debts for dual eligible beneficiaries (see instructions) ssts - current cost reporting period (line 26 plus line 27) DJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  ACO demonstration payment adjustment (see instructions) (see instructions) ration adjustment (see instructions) payments (see instructions)	sable bad debts for dual eligible beneficiaries (see instructions)  sts - current cost reporting period (line 26 plus line 27)  DUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  ACO demonstration payment adjustment (see instructions)  (see instructions)  ration adjustment (see instructions)  payments (see instructions)  ve settlement (for contractor use only)  0 890,504  872,694

Health Financial Systems HENRY COUNTY MEMO ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 2/15/2017 2:11 pm PPS Provider CCN: 15-0030 HHA CCN: 15-7430

				Home Health Agency I	PPS	. р
		Inpatien	t Part A		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			0	872, 694	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01				0	0	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3. 04 3. 05				0	0 0	3. 04 3. 05
3.03	Provider to Program			<u> </u>	0	3. 03
3.50	. revider to rregidin			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53 3. 54				0	0 0	3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 99
0. 77	3. 50-3. 98)					0. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)			o	872, 694	4.00
	(transfer to Wkst. H-4, Part II, column as appropriate,					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					- 04
5. 01 5. 02				0	0 0	5. 01 5. 02
5. 02				0		5. 02
0.00	Provider to Program					0.00
5.50				0	0	5. 50
5. 51				0	0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 52 5. 99
5. 99	5. 50-5. 98)			O .	٥	5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0 072 (04	6. 02
7. 00	Total Medicare program liability (see instructions)			Contractor	872, 694 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
			)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Health Financial Systems	HENRY COUNTY MEMOR	RLAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS		Provi der CC		Period: From 01/01/2015	Worksheet K	
		Hospi ce CCN	: 15-1564	To 12/31/2015	Date/Time Pre 2/15/2017 2:1	
				Hospi ce I		
	Salaries (from		Transportation	on Contracted	Other	

			nospi ce coi	N. 15-1504	10 12/31/2013	2/15/2017 2:1	
					Hospi ce I		
		Salaries (from	Employee	Transportati o		Other	
			enefits (from				
		Í .	Wkst. K-2)	`	Wkst. K-3)		
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.				0	0	1. 00
2.00	Capital Related Costs-Movable Equip.				O	0	2. 00
3.00	Plant Operation and Maintenance	0	0		0	0	3. 00
4.00	Transportation - Staff	0	0		0	0	4. 00
5.00	Volunteer Service Coordination	0	0		0	0	5. 00
6.00	Administrative and General	76, 931	0		0	491, 059	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0		0 0	0	7. 00
8.00	Inpatient - Respite Care	0	0		0 0	0	8. 00
	VISITING SERVICES						
9.00	Physician Services	2, 100	0		0	0	9. 00
10.00	Nursi ng Care	189, 770	0		0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12.00	Physi cal Therapy	0	0		0	0	12.00
13.00	Occupational Therapy	0	0		0	0	13. 00
14.00	Speech/ Language Pathology	0	0		0	0	14. 00
15.00	Medical Social Services	38, 460	0		0	0	15. 00
16.00	Spiritual Counseling	0	0		0	0	16. 00
17.00	Di etary Counsel i ng	0	0		0	0	17. 00
18.00	Counseling - Other	0	0		0	0	18. 00
19.00	Home Health Aide and Homemaker	22, 556	0		0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20. 00
21. 00	Other	0	0		0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22. 00
23. 00	Anal gesi cs	0	0		0	0	23. 00
24. 00	Sedatives / Hypnotics	0	0		0	0	24. 00
25. 00	Other - Specify	0	0		0 0	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0		0	0	26. 00
27. 00	Patient Transportation	0	0		0	0	27. 00
28. 00	I maging Services	0	0		0	0	28. 00
29. 00	Labs and Diagnostics	0	0		0	0	29. 00
30. 00	Medical Supplies	0	0		0	0	30. 00
31. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	31. 00
32. 00	Radiation Therapy	0	0		0	0	32. 00
33.00	Chemotherapy	0	0		0	0	33. 00
34.00	Other	0	0		0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35. 00	Bereavement Program Costs	0	0	•	0	0	35. 00
36. 00	Volunteer Program Costs	0	0		0	0	36. 00
37. 00	Fundrai si ng	0	0		0	0	37. 00
38. 00	Other Program Costs	0	0		0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	329, 817	0	1	0	491, 059	39.00

Heal th	Financial Systems	HENRY COUNTY MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED HOSPICE COSTS		Provi der CC		Period: From 01/01/2015	Worksheet K	
			Hospi ce CCN			Date/Time Prep 2/15/2017 2:1	oared: 1 pm
					Hospi ce I		
	·	Total (cols. R	ecl assi fi cati	Subtotal (col	. Adjustments	Total (col. 8	
		1-5)	on	$6 \pm col. 7$	•	± col. 9)	
		6.00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0		0 0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0		0 0	ol	2.00
3.00	Plant Operation and Maintenance	O	o		o o	ol	3.00
4.00	Transportation - Staff	l ol	ol		o o	0	4.00

		1-5)	on	6 ± col. 7)	,	± col. 9)	
		6.00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1. 00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2. 00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3. 00
4.00	Transportation - Staff	0	0	0	0	0	4. 00
5.00	Volunteer Service Coordination	0	0	0	0	0	5. 00
6.00	Administrative and General	567, 990	-25, 775	542, 215	4, 202	546, 417	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7. 00
8.00	Inpatient - Respite Care	0	0	0	0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	2, 100	0	2, 100	0	2, 100	9. 00
10.00	Nursi ng Care	189, 770	0	189, 770	0	189, 770	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11. 00
12.00	Physi cal Therapy	0	0	0	0	0	12. 00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	38, 460	0	38, 460	0	38, 460	15. 00
16.00	Spiritual Counseling	0	0	0	0	0	16. 00
17. 00	Di etary Counsel i ng	0	0	0	0	0	17. 00
18.00	Counseling - Other	0	0	0	0	0	18. 00
19. 00	Home Health Aide and Homemaker	22, 556	0	22, 556	0	22, 556	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	o	O	0	0	0	20.00
21.00	Other	0	0	0	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22. 00
23.00	Anal gesi cs	0	0	0	0	0	23. 00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24. 00
25.00	Other - Specify	0	0	0	0	0	25. 00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26. 00
27.00	Patient Transportation	0	0	0	0	0	27. 00
28. 00	I maging Services	0	0	0	0	0	28. 00
29. 00	Labs and Diagnostics	0	0	0	0	0	29. 00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31. 00
32.00	Radiation Therapy	0	0	0	0	0	32. 00
33.00	Chemotherapy	0	0	0	0	0	33. 00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35. 00
36.00	Volunteer Program Costs	0	0	О	o	0	36. 00
37.00	Fundrai si ng	0	o	0	o	0	37. 00
38.00	Other Program Costs	o	o	0	o	0	38. 00
39.00	Total (sum of lines 1 thru 38)	820, 876	-25, 775	795, 101	4, 202	799, 303	39. 00
		·		·	•		

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Li	eu of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES		Provider CCN: 15-0030	Peri od:	Worksheet K-1

From 01/01/2015 To 12/31/2015 Hospi ce CCN: 15-1564 Date/Time Prepared: 2/15/2017 2:11 pm Hospi ce I Admi ni strator Di rector Soci al Nurses Supervi sors Servi ces 1.00 2.00 4. 00 5. 00 3 00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 1.00 Capital Related Costs-Movable Equip. 2.00 2.00 3.00 0 3.00 Plant Operation and Maintenance 0 0 0 4.00 Transportation - Staff 0 0 0 4.00 5.00 Volunteer Service Coordination 0 5.00 0 6.00 Administrative and General 76, 931 0 0 0 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 0 0 0 0 7.00 8.00 0 0 0 0 0 8.00 VISITING SERVICES 9.00 Physi ci an Servi ces 0 0 0 0 0 9.00 0 10.00 Nursing Care 0 0 0 189, 770 10.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 11.00 0 11.00 0 0 12.00 Physical Therapy 0 12.00 0 13.00 Occupational Therapy 0 0 0 13.00 Speech/ Language Pathology 14.00 14.00 Medical Social Services 0 15.00 38, 460 15.00 0 0 16.00 Spiritual Counseling 0 0 16.00 17.00 Dietary Counseling 0 17.00 0 18.00 Counseling - Other 0 18.00 Home Heal th Aide and Homemaker 0 19.00 19.00 0 0 20.00 HH Aide & Homemaker - Cont. Home Care C 0 20.00 21.00 0 21.00 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 22.00 23.00 Anal gesi cs 23.00 Sedatives / Hypnotics 24.00 24.00 Other - Specify 25.00 25.00 Durable Medical Equipment/Oxygen 26.00 26.00 27.00 Patient Transportation 0 27.00 0 28. 00 Imaging Services 00000 0 0 0 0 0 28.00 29 00 Labs and Diagnostics Ω 0 29.00 0 30.00 Medical Supplies 0 30.00 0 31.00 Outpatient Services (including E/R Dept.) 0 0 31.00 Radiation Therapy 0 32.00 0 0 32.00 0 0 33.00 Chemotherapy 0 33.00 34.00 0ther 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35 00 0 0 0 n 35.00 Bereavement Program Costs 0 0 0 36.00 Volunteer Program Costs 0 0 36.00 37.00 Fundrai si ng 0 0 0 0 37.00 0

0

76, 931

0

O

0

38, 460

0 38.00

189, 770 39. 00

38.00

Other Program Costs

39.00 Total (sum of lines 1 thru 38)

Heal th	Financial Systems H	ENRY COUNTY MEM	ODIAI HOSDITAI		Inlie	eu of Form CMS-2	2552_10
	E COMPENSATION ANALYSIS SALARIES AND WAGES	LINICI COUNTT INLIN	Provi der Co	N. 15 0020	Peri od:	Worksheet K-1	
позетс	E COMPENSATION ANALISIS SALARIES AND WAGES			N: 15-1564	From 01/01/2015	Date/Time Pre 2/15/2017 2:1	pared:
-					Hospi ce I	27 107 2017 2.1	Гри
		Total Therapists	Ai des	All-Other	Total (1)		
		6.00	7. 00	8. 00	9. 00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0		0		3. 00
4. 00	Transportation - Staff		0		0		4. 00
5. 00	Volunteer Service Coordination		0		0 0		5. 00
6. 00	Administrative and General		0		0 76, 931		6.00
0.00	I NPATI ENT CARE SERVI CE				70,701		0.00
7. 00	Inpatient - General Care		0		0 0		7. 00
8. 00	Inpatient - Respite Care		0		0 0		8.00
0.00	VI SI TI NG SERVI CES				9 0		0.00
9. 00	Physician Services		0	2, 1	00 2, 100		9. 00
10. 00	Nursing Care		0	2, 1	0 189, 770		10.00
11. 00	Nursing Care-Continuous Home Care		0		0 187,770		11. 00
12. 00		0	0				12.00
13. 00	Occupational Therapy	0	0				13. 00
	Speech/ Language Pathology	0	0		0		14. 00
15. 00		U	0		0 38, 460		15. 00
	Spiritual Counseling		0		0 30, 400		16. 00
	Di etary Counseling		0		0		17. 00
	Counseling - Other		0		0		18.00
	Home Health Aide and Homemaker		22 554		0 22 554		19.00
19.00	4		22, 556		0 22, 556		
	HH Aide & Homemaker - Cont. Home Care		0		0 0		20.00
21.00	Other OTHER HOSPICE SERVICE COSTS		U		0 0		21. 00
22.00		T					22 00
22. 00							22. 00
	Anal gesi cs						23. 00
24. 00	1						24. 00
	Other - Specify						25. 00
26. 00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						26. 00
27. 00			0		0		27. 00
28. 00	I maging Services		0		0		28. 00
	Labs and Diagnostics		0		0		29. 00
30.00	Medical Supplies		0		0 0		30.00
31. 00			0		0		31.00
32. 00	Radiation Therapy		0		0 0		32. 00
33. 00	Chemotherapy		0		0 0		33. 00
34. 00	Other		0		0 0		34. 00

0

22, 556

35.00

36.00 37. 00

38.00

39. 00

0 0 0

2, 100

36.00

HOSPI CE NONREI MBURSABLE SERVI CE
35.00 Bereavement Program Costs

Volunteer Program Costs

38.00 Other Program Costs 39.00 Total (sum of lines 1 thru 38)

37. 00 Fundrai si ng

AL HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-0030 | Period: From 01/01/2015 | Worksheet K-4 | Part I | Date/Time Prepared: 2/15/2017 2:11 pm Health Financial Systems

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

						2/15/2017 2:1	1 pm
					Hospi ce I		
			CAPITAL RE	LATED COST			
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATION	
		FOR COST	FI XTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MAI NT.		
		0	1.00	2. 00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0			0		2. 00
3.00	Plant Operation and Maintenance	0	0		0 0		3. 00
4.00	Transportation - Staff	0	0		0 0	0	4. 00
5.00	Volunteer Service Coordination	0	0		0 0	0	5. 00
6.00	Administrative and General	546, 417	0		0 0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0		0 0	0	7. 00
8.00	Inpatient - Respite Care	0	0		0 0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	2, 100	0		0 0	0	9. 00
10.00	Nursi ng Care	189, 770	0		0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	11. 00
12.00	Physical Therapy	o	0		0 0	0	12.00
13.00	Occupational Therapy	o	0		0 0	0	13. 00
14.00	Speech/ Language Pathology	o	0		0 0	0	14. 00
15.00	Medical Social Services	38, 460	0		0 0	0	15. 00
16.00	Spiritual Counseling	0	0		0 0	0	16. 00
17.00	Di etary Counseling	O	0		0 0	0	17. 00
18.00	Counseling - Other	o	0		0 0	0	18. 00
19.00	Home Health Aide and Homemaker	22, 556	0		0 0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	O	0		0 0	0	20. 00
21.00	Other	o	0		0 0	0	21. 00
	OTHER HOSPICE SERVICE COSTS	<u>'</u>					
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22. 00
23.00	Anal gesi cs	O	0		0 0	0	23. 00
24.00	Sedatives / Hypnotics	O	0		0 0	0	24. 00
25.00	Other - Specify	o	0		0 0	0	25. 00
26.00	Durable Medical Equipment/Oxygen	o	0		0 0	0	26. 00
27.00	Patient Transportation	o	0		0 0	0	27. 00
28.00	Imaging Services	o	0		0 0	0	28. 00
29.00	Labs and Diagnostics	o	0		0 0	0	29. 00
30.00	Medical Supplies	o	0		0 0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	o	0		0 0	0	31.00
32.00	Radiation Therapy	o	0		0 0	0	32.00
33. 00	Chemotherapy	0	0		0 0	0	33. 00
34. 00	Other	0	0		0 0		34.00
	HOSPI CE NONREI MBURSABLE SERVI CE		<u> </u>				
35. 00	Bereavement Program Costs	0	0		0 0	0	35. 00
36. 00	Volunteer Program Costs		0		0		36.00
37. 00	Fundrai si ng		n		0	Ö	37. 00
38. 00	Other Program Costs		0			1	38. 00
	Total (sum of lines 1 thru 38)	799, 303	0		0		1
07.00	1 ( 0		٥	ı	-1	1	37.00

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	In Lieu of Form CMS-2552-10	
COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 15-0030	Peri od:	Worksheet K-4	

From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared: Hospi ce CCN: 15-1564 2/15/2017 2:11 pm Hospi ce I VOLUNTEER SUBTOTAL ADMINISTRATIVE TOTAL (col. 5A SERVI CES (cols. 0 - 5)& GENERAL ± col. 6) COORDI NATOR 5A 6.00 7. 00 5.00 GENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt. 1.00 2.00 Capital Related Costs-Movable Equip. 2.00 3.00 Plant Operation and Maintenance 3.00 4.00 Transportation - Staff 4.00 5.00 Volunteer Service Coordination 5.00 546, 417 Administrative and General 0 546, 417 6.00 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 0 0 7.00 8.00 0 0 8.00 0 VISITING SERVICES 9.00 Physician Services 0 2, 100 4,538 6,638 9.00 10.00 Nursing Care 00000000000 189, 770 410, 041 599, 811 10.00 Nursing Care-Continuous Home Care 11.00 11.00 0 0 12.00 Physical Therapy 0 0 12.00 13.00 Occupational Therapy 0 13.00 Speech/ Language Pathology Medical Social Services 14.00 14.00 15.00 15.00 38, 460 83, 101 121, 561 16.00 Spiritual Counseling C 0 16.00 Dietary Counseling 0 17.00 17.00 0 Counseling - Other 0 18.00 18.00 22, 556 19.00 Home Health Aide and Homemaker 48, 737 71, 293 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 20.00 0 21.00 0ther 0 0 0 21.00 OTHER HOSPICE SERVICE COSTS 0 22.00 Drugs, Biological and Infusion Therapy 0 0 22.00 23.00 Anal gesi cs 0 0 0 0 0 0 0 0 0 0 0 0 0 23.00 0 24.00 Sedatives / Hypnotics 0 0 0 24.00 Other - Specify 0 0 25.00 25.00 26.00 Durable Medical Equipment/Oxygen 26.00 0 27.00 Patient Transportation 0 0 0 0 0 27.00 Imaging Services 28 00 0 0 28 00 0 29.00 Labs and Diagnostics 29.00 0 30.00 Medical Supplies 0 30.00 0 31.00 Outpatient Services (including E/R Dept.) 0 31.00 32 00 0 0 32.00 Radiation Therapy 0 33.00 Chemotherapy 0 33.00 34.00 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 0 0 35.00 0 36.00 Volunteer Program Costs 0 0 36.00 37.00 Fundrai si ng 0 0 0 37.00 Other Program Costs 0 38.00 38.00 0

799, 303

799, 303

39.00

39.00 Total (sum of lines 1 thru 38)

AL HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-0030 | Period: From 01/01/2015 | Worksheet K-4 | Part II | Date/Time Prepared: 2/15/2017 2:11 pm

			nospi ce coi		12/01/2010	2/15/2017 2:1	1 pm
					Hospi ce I		
		CAPITAL REL	ATED COST		'		
		BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATION	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.	, ,	COORDI NATOR	
		' ' '	***************************************	FT. )		(HOURS)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.		0				2.00
3.00	Plant Operation and Maintenance		0		0		3.00
4. 00	Transportation - Staff		0		0 0		4.00
			0		-1		
5.00	Volunteer Servi ce Coordination	0	0		0 0		5.00
6.00	Administrative and General	0	0		0 0	0	6.00
	I NPATI ENT CARE SERVI CE				_	_	
7.00	Inpatient - General Care	0	0		0		7. 00
8.00	Inpatient - Respite Care	0	0		0 0	0	8. 00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	0	0		0		9. 00
10.00	Nursing Care	0	0		0	1	10. 00
11. 00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12.00	Physi cal Therapy	0	0		0	0	12. 00
13.00	Occupational Therapy	0	0		0 0	0	13. 00
14.00	Speech/ Language Pathology	o	0		0 0	0	14. 00
15.00	Medical Social Services	o	0		0 0	0	15. 00
16.00	Spiritual Counseling	l ol	0		0	0	16. 00
17. 00	Di etary Counsel i ng	0	0		0 0		17. 00
18. 00	Counseling - Other		0		0 0	0	18. 00
19. 00	Home Health Aide and Homemaker		0		0 0	Ö	19.00
20. 00	HH Ai de & Homemaker - Cont. Home Care		0		0 0		20.00
21. 00	Other		0		0 0		
21.00	OTHER HOSPICE SERVICE COSTS	U <sub>I</sub>			0 0	l 0	21.00
22. 00	Drugs, Biological and Infusion Therapy	O	0		0 0	0	22. 00
23. 00			0		0 0	•	23.00
	Anal gesi cs		-			1	
24. 00	Sedatives / Hypnotics	0	0		0 0		24. 00
25. 00	Other - Specify	0	0		0	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0		0	0	26. 00
27. 00	Patient Transportation	0	0		0	1	27. 00
28. 00	I maging Services	0	0		0	1	28. 00
29. 00	Labs and Diagnostics	0	0		0	1	29. 00
30.00	Medical Supplies	0	0		0	0	30. 00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32.00	Radiation Therapy	0	0		0 0	0	32. 00
33.00	Chemotherapy	o	0		0 0	0	33. 00
34.00	Other	o	0		0 0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE				•		
35.00	Bereavement Program Costs	0	0		0 0	0	35. 00
36. 00	Volunteer Program Costs	ol	0		0 0	0	36.00
37. 00	Fundrai si ng		0		0 0	Ō	37. 00
38. 00	Other Program Costs	l o	0		0 0	Ö	38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)	ا	0		0 0	Ö	39. 00
	Unit Cost Multiplier	0. 000000	0. 000000	0. 00000	0. 000000		
<del>-</del> 0.00	John C 003C mai ti pi i ci	0.000000	0. 000000	1 0.00000	J. 000000	1 0.000000	1 70.00

2/15/2017 2:11 pm Hospi ce I RECONCI LI ATI ON ADMI NI STRATI VE & GENERAL (ACC. COST) 6A 6.00 GENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt. 1.00 0 2.00 Capital Related Costs-Movable Equip. 2.00 3.00 Plant Operation and Maintenance 0 3.00 4.00 Transportation - Staff 0 4.00 5.00 Volunteer Service Coordination 5.00 Administrative and General 252, 886 6.00 -546, 417 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 7.00 8.00 0 0 8.00 VISITING SERVICES 9.00 Physician Services 2, 100 9.00 10.00 Nursing Care 00000000000 189, 770 10.00 Nursing Care-Continuous Home Care 11.00 11.00 0 12.00 Physical Therapy 0 12.00 13.00 Occupational Therapy 13.00 Speech/ Language Pathology Medical Social Services 14.00 14.00 15.00 15.00 38, 460 16.00 Spiritual Counseling 0 16.00 Dietary Counseling 17.00 17.00 0 Counseling - Other 18.00 18.00 Home Health Aide and Homemaker 19.00 22, 556 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 20.00 0 21.00 0ther 0 21.00 OTHER HOSPICE SERVICE COSTS Drugs, Biological and Infusion Therapy 0 22.00 0 22.00 23. 00 Anal gesi cs 0 23.00 0 0 0 0 0 0 0 0 0 24.00 Sedatives / Hypnotics 0 24.00 Other - Specify 0 25.00 25.00 26.00 Durable Medical Equipment/Oxygen 0 26.00 0 27.00 Patient Transportation 27.00 28 00 Imaging Services 0 28.00 Labs and Diagnostics 0 29.00 29.00 30.00 Medical Supplies 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 31.00 32.00 Radiation Therapy 0 32.00 33.00 Chemotherapy 0 33.00 34.00 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 36.00

0

0

546, 417

2. 160725

37.00

38.00

39.00

40.00

37.00

Fundrai si ng

38.00 Other Program Costs

40.00 Unit Cost Multiplier

39.00 | Cost to be Allocated (per Wkst. K-4, Part I)

AL HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-0030 | Period: From 01/01/2015 | Part I | Date/Time Prepared: 2/15/2017 2:11 pm Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provider CO

						2/15/2017 2:1	1 pm
					Hospi ce I		
	·		CAPI TAL REI	_ATED_COSTS			
	Cost Center Description	Hospi ce Tri al	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
		Bal ance (1)	FIXT	EQUI P	BENEFI TS		
					DEPARTMENT		
		0	1.00	2. 00	4. 00	4A	
1.00	Administrative and General		0	0	94, 745	94, 745	1. 00
2.00	Inpatient - General Care	0	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	6, 638	0	0	0	6, 638	4. 00
5.00	Nursing Care	599, 811	0	0	0	599, 811	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	121, 561	0	0	0	121, 561	10.00
11. 00	Spiritual Counseling	0	0	0	0	0	11. 00
12.00	Di etary Counseling	0	0	0	0	0	12. 00
13.00	Counseling - Other	0	0	0	0	0	13. 00
14.00	Home Health Aide and Homemaker	71, 293	0	0	0	71, 293	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	O	0	0	0	0	15. 00
16.00	Other	0	0	0	0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18.00	Anal gesi cs	0	0	0	0	0	18. 00
19.00	Sedatives / Hypnotics	O	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	O	0	0	0	0	21. 00
22.00	Patient Transportation	o	0	0	0	0	22. 00
23.00	I maging Services	O	0	0	0	0	23. 00
24.00	Labs and Diagnostics	o	0	0	0	0	24. 00
25.00	Medical Supplies	o	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	o	0	0	0	0	26. 00
27.00	Radi ati on Therapy	O	0	0	0	0	27. 00
28. 00	Chemotherapy	O	0	0	0	0	28. 00
29.00	Other	O	0	0	0	0	29. 00
30.00	Bereavement Program Costs	O	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31. 00
32.00	Fundrai si ng	o	0	0	0	0	32. 00
33. 00	Other Program Costs	0	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	799, 303	0	0	94, 745	894, 048	34.00
35. 00	Unit Cost Multiplier (see instructions)				•	0	35. 00
		, ,		•			

Health Financial Systems HENRY COUNTALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Period: Worksheet K-5
From 01/01/2015 Part I
To 12/31/2015 Date/Time Prepared: 2/15/2017 2:11 pm Provi der CCN: 15-0030 Hospi ce CCN: 15-1564

						2/15/2017 2:1	ι μιι
					Hospi ce I		
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
1.00	Administrative and General	22, 512	0	0	0	0	1. 00
2.00	Inpatient - General Care	0	0	0	0	0	
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	1, 577	0	0	0	0	4. 00
5.00	Nursi ng Care	142, 517	0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	28, 883	0	0	0	0	10.00
11. 00	Spiritual Counseling	0	0	0	0	0	11. 00
12.00	Di etary Counsel i ng	0	0	0	0	0	12. 00
13.00	Counseling - Other	0	0	0	0	0	13. 00
14.00	Home Health Aide and Homemaker	16, 939	0	0	0	0	14.00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15. 00
16. 00	Other	0	0	0	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18. 00	Anal gesi cs	0	Ó	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	o o	0	0	19. 00
20.00	Other - Specify	0	Ó	0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0	Ó	0	0	21. 00
22. 00	Pati ent Transportation	0	0	Ó	0	0	22. 00
23. 00	I maging Services	0	0	Ó	0	0	23. 00
24. 00	Labs and Diagnostics	0	0	Ó	0	0	24. 00
25. 00	Medical Supplies	0	0	0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27. 00	Radiation Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	29. 00
30. 00	Bereavement Program Costs	0	0	0	0	0	30.00
31. 00	Volunteer Program Costs	0	0	0	0	0	31. 00
32. 00	Fundrai si ng	0	0	0	0	0	32. 00
33. 00	Other Program Costs	0	ĺ	ا م	n	0	33.00
34. 00	Total (sum of lines 1 thru 33) (2)	212, 428	١	ا ا	l ő	0	34.00
35. 00		2.2, 120					35. 00
55.50	10 t 333t mai ti pi i 61 (365 i ii3ti 46ti 613)	1		I		l	1 30.00

AL HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-0030 | Period: From 01/01/2015 | Part I | Date/Time Prepared: 2/15/2017 2:11 pm Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provider CO

						2/15/2017 2:1	1 pm
				_	Hospi ce I		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON			RECORDS &	
				SUPPLY		LI BRARY	
	T	11. 00	13. 00	14. 00	15. 00	16. 00	
1.00	Administrative and General	C	1	2, 680	0	10, 881	1. 00
2.00	Inpatient - General Care	C	0	0	0	0	2. 00
3.00	Inpatient - Respite Care		0	0	0	0	3. 00
4.00	Physi ci an Servi ces		0	0	0	0	4. 00
5.00	Nursing Care		0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care		0	0	0	0	6. 00
7.00	Physi cal Therapy		0	0	0	0	7. 00
8.00	Occupational Therapy		0	0	0	0	8. 00
9.00	Speech/ Language Pathology		0	0	0	0	9. 00
10.00	Medical Social Services		0	0	0	0	10.00
11.00	Spiritual Counseling		0	0	0	0	11.00
12.00	Di etary Counsel i ng			0	0	0	12.00
13.00	Counseling - Other			0	0	0	13.00
14.00	Home Health Aide and Homemaker			0	0	0	14.00
15. 00	HH Aide & Homemaker - Cont. Home Care			0	0	0	15.00
16.00	Other			0	0	0	16.00
17. 00	Drugs, Biological and Infusion Therapy			0	0	0	17. 00
18.00	Anal gesi cs			0	0	0	18.00
19. 00	Sedatives / Hypnotics			0	0	0	19.00
20.00	Other - Specify			0	0	0	20. 00 21. 00
21. 00	Durable Medical Equipment/Oxygen			0	0	0	
22. 00 23. 00	Patient Transportation			0	0	0	22. 00 23. 00
24. 00	I maging Services			0	0	0	24.00
25. 00	Labs and Diagnostics Medical Supplies			0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)			0	0	0	26. 00
27. 00	Radi ati on Therapy			0	0	0	27.00
28. 00	Chemotherapy			0	0	0	28. 00
29. 00	Other			0	0	0	29. 00
30.00	Bereavement Program Costs			0	0	0	30.00
31. 00	Volunteer Program Costs			0	0	0	31.00
32. 00	Fundrai si ng			0	0	0	32.00
32.00	Other Program Costs				0	0	32.00
34. 00	Total (sum of lines 1 thru 33) (2)			2, 680	0	10, 881	34.00
35. 00			ή '	2, 080	U	10, 881	35.00
33.00	Joint Cost Multiplier (See Histractions)	I	I	I	ļ		33.00

	LINICI COUNTT MEM			TIT LIC	u or rorm cws-2	2332-10
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST	Γ CENTERS	Provi der CO		Peri od:	Worksheet K-5	
				From 01/01/2015		
		Hospi ce CCI	N: 15-1564	Γο 12/31/2015		
				Henri en 1	2/15/2017 2:1	т рііі
				Hospi ce I	T	
Cost Center Description	Subtotal	Intern &	Subtotal	Allocated	Total Hospice	
	(COLS. 4A-23)	Residents Cost		Hospi ce A&G	Costs (cols.	
		& Post	25)	(See Part II)	26 ± 27)	
		Stepdown				
		Adjustments				
	24.00	25. 00	26. 00	27. 00	28. 00	
1.00 Administrative and General	130, 818					1. 00
2.00 Inpatient - General Care	0	0		0	0	2. 00
3.00 Inpatient - Respite Care	0	0	(	0	0	3. 00
4.00 Physician Services	8, 215	0	8, 21!	5 1, 086	9, 301	4. 00
5.00 Nursing Care	742, 328	0	742, 328	98, 169	840, 497	5. 00
6.00 Nursing Care-Continuous Home Care	o	0		0	0	6. 00
7.00 Physical Therapy	o	0		0	0	7. 00
8.00 Occupational Therapy	o	0		0	0	8. 00
9.00 Speech/ Language Pathology	l ol	0		0	0	9.00
10.00 Medical Social Services	150, 444	0	150, 44	19, 895	170, 339	
11.00 Spiritual Counseling	0	0	1 .00,	) .,,,,,,	0	11.00
12.00 Dietary Counseling		0		0	0	12. 00
13. 00   Counsel i ng - Other		0		0	0	13. 00
14.00 Home Health Aide and Homemaker	88, 232	0	88, 232	11, 668		
15. 00 HH Ai de & Homemaker - Cont. Home Care	00, 232	0	00, 23,	11,000	77, 700	15. 00
16.00 Other		0	)	0	0	16. 00
	0	0	)			•
17.00 Drugs, Biological and Infusion Therapy	0	0			0	17. 00
18. 00 Anal gesi cs	0	0		0	0	18. 00
19.00 Sedatives / Hypnotics	0	0		0	0	19. 00
20. 00 Other - Specify	0	0	9	) 0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	(	0	0	21. 00
22.00 Patient Transportation	0	0	(	0	0	22. 00
23.00 Imaging Services	0	0	(	0	0	23. 00
24.00 Labs and Diagnostics	0	0	(	0	0	24. 00
25.00 Medical Supplies	0	0		0	0	25. 00
26.00 Outpatient Services (including E/R Dept.)	0	0	(	0	0	26. 00
27.00 Radiation Therapy	0	0	(	0	0	27. 00
28.00 Chemotherapy	0	0	(	0	0	28. 00
29.00 Other	0	0	(	0	0	29. 00
30.00 Bereavement Program Costs	o	0		0	0	30.00
31.00 Volunteer Program Costs	o	0		0	0	31.00
32.00 Fundrai si ng	o	0		0	0	32.00
33.00 Other Program Costs	0	0		0	0	•
34.00 Total (sum of lines 1 thru 33) (2)	1, 120, 037	0	1, 120, 03	7	1, 120, 037	34. 00
35.00 Unit Cost Multiplier (see instructions)	1, 123, 307	· ·	1, .20, 00	0. 132244		35. 00
11. 11   1 1   0.00 t mail tipinoi (0.00 1ot. dottono)	1		1	332211	1	, 55. 55

| In Lieu of Form CMS-2552-10 | Worksheet K-5 | Part II | Date/Time Prepared: | 2/15/2017 2:11 pm Peri od: From 01/01/2015 To 12/31/2015 STATISTICAL BASIS Hospi ce CCN: 15-1564 Hospi ce I

		CAPITAL REL	ATED COSTS		110001.00		
		0,11,1,12,1,12	25 000.0				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	occi contor boson per on	FLXT	EQUI P	BENEFITS		& GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
			,	SALARI ES)		300.7	
		1.00	2.00	4.00	5A	5. 00	
1.00	Administrative and General	0	0	333, 729	C	94, 745	1. 00
2.00	Inpatient - General Care	0	0	C	C	o	2. 00
3.00	Inpatient - Respite Care	0	0	C	C	o	3. 00
4.00	Physi ci an Servi ces	0	0	C	C	6, 638	4. 00
5.00	Nursi ng Care	o	0	C	0	599, 811	5. 00
6.00	Nursing Care-Continuous Home Care	o	0	C	0	0	6. 00
7.00	Physical Therapy	o	0	C	0	0	7. 00
8.00	Occupational Therapy	o	0	C	0	o	8. 00
9.00	Speech/ Language Pathology	o	0	C	0	o	9. 00
10.00	Medical Social Services	0	0	C	C	121, 561	10.00
11.00	Spiritual Counseling	0	0	C	0	0	11.00
12.00	Di etary Counsel i ng	0	0	C	0	0	12.00
13.00	Counseling - Other	0	0	C	C	0	13.00
14.00	Home Health Aide and Homemaker	0	0	C	0	71, 293	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	C	0	0	15.00
16.00	Other	o	0	C	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	C	0	0	17.00
18.00	Anal gesi cs	0	0	C	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	C	0	0	19.00
20.00	Other - Specify	0	0	C	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	C	0	0	21.00
22. 00	Patient Transportation	0	0	C	0	0	22. 00
23.00	I maging Services	0	0	C	0	0	23.00
24.00	Labs and Diagnostics	0	0	C	0	0	24.00
25.00	Medical Supplies	0	0	C	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	C	0	0	26.00
27.00	Radi ati on Therapy	o	0	l c	O	o	27. 00
28.00	Chemotherapy	o	0	l c	O	o	28. 00
29. 00	Other	o	0	l c	) C	o	29. 00
30.00	Bereavement Program Costs	o	0	l c	) C	o	30.00
31.00	Volunteer Program Costs	o	0		) C	o	31.00
32.00	Fundrai si ng	o	0	l c	0	ol	32. 00
33.00	Other Program Costs	o	0		) C	o	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	ol	0	333, 729		894, 048	34. 00
35. 00	Total cost to be allocated	l	0	94, 745		212, 428	35. 00
	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000			0. 237602	
	The state of the s				į.		

			1103	or ce cci	1. 15-1504	10	12/31/2015	2/15/2017 2:1	
							Hospi ce I		
	Cost Center Description	OPERATION OF	LAUNE	RY &	HOUSEKEEPI	NG	DI ETARY	CAFETERI A	
		PLANT	LINEN S	SERVI CE	(HOURS OF		(PATIENT	(FTE'S)	
		(SQUARE	(POUN		SERVI CE)		DAYS)		
		FEET)	LAUN						
		7. 00	8.	00	9. 00		10. 00	11. 00	
1.00	Administrative and General	0		0		0	0	0	
2.00	Inpatient - General Care	0		0		0	0	0	
3.00	Inpatient - Respite Care	0		0		0	0	0	
4.00	Physi ci an Servi ces	0		0		0	0	0	
5.00	Nursing Care	0		0		0	0	0	
6.00	Nursing Care-Continuous Home Care	0		0		0	0	0	
7.00	Physi cal Therapy	0		0		0	0	0	
8.00	Occupational Therapy	0		0		0	0	0	
9.00	Speech/ Language Pathology	0		0		0	0	0	
10.00	Medical Social Services	0		0		0	0	0	
11. 00	Spiritual Counseling	0		0		0	0	0	
12.00	Di etary Counseling	0		0		0	0	0	
13.00	Counseling - Other	0		0		0	0	0	
14. 00	Home Health Aide and Homemaker	0		0		0	0	0	
15. 00	HH Aide & Homemaker - Cont. Home Care	0		0		0	0	0	
16. 00	Other	0		0		0	0	0	
17. 00	Drugs, Biological and Infusion Therapy	0		0		0	0	0	
18. 00	Anal gesi cs	0		0		0	0	0	
19. 00	Sedatives / Hypnotics	0		0		0	0	0	
20. 00	Other - Specify	0		0		0	0	0	
21. 00	Durable Medical Equipment/Oxygen	0		0		0	0	0	
22. 00	Pati ent Transportation	0	)	0		0	0	0	
23. 00	I maging Services	0	)	0		0	0	0	
24. 00	Labs and Diagnostics	0		0		0	0	0	
25. 00	Medical Supplies	0		0		0	0	0	
26. 00	Outpatient Services (including E/R Dept.)	0		0		0	0	0	
27. 00	Radiation Therapy	0	)	0		0	0	0	
28. 00	Chemotherapy	0	)	0		0	0	0	
29. 00	Other	0	)	0		0	0	0	
30.00	Bereavement Program Costs	0	)	0		0	0	0	30.00
31.00	Volunteer Program Costs	0	)	0		0	0	0	
32.00	Fundrai si ng	0	)	0		0	0	0	
33.00	Other Program Costs	0	)	0		0	0	0	
34.00	Total (sum of lines 1 thru 33) (2)	0	)	0		0	0	0	
35. 00	Total cost to be allocated	0	)	0		0	0	0	
36. 00	Unit Cost Multiplier (see instructions)	0. 000000	0	. 000000	0.000	000	0.000000	0.000000	36. 00

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO STATISTICAL BASIS	HOSPICE COST CENTERS	Provi der CCN: 15-0030	Peri od: From 01/01/2015	Worksheet K-5
STATISTICAL BASIS		Hospi ce CCN: 15-1564		Date/Time Prepared:

			nospi ce cci	1. 13-1304	10	12/31/2013	2/15/2017 2:1	
						Hospi ce I		<u> </u>
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		MEDI CAL		
	·	ADMI NI STRATI ON	SERVICES &	(COSTED		RECORDS &		
			SUPPLY	REQUIS.)		LI BRARY		
		(DI RECT	(COSTED			(TIME		
		NRSING HRS)	REQUIS.)			SPENT)		
		13.00	14. 00	15. 00		16. 00		
1.00	Administrative and General	0	11, 682		0	16		1. 00
2.00	Inpatient - General Care	0	0		0	0		2. 00
3.00	Inpatient - Respite Care	0	0		0	0		3. 00
4.00	Physi ci an Servi ces	0	0		0	0		4. 00
5.00	Nursing Care	0	0		0	0		5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0	0		6. 00
7.00	Physi cal Therapy	0	0		0	0		7. 00
8.00	Occupational Therapy	0	0		0	0		8. 00
9.00	Speech/ Language Pathology	0	0		0	0		9. 00
10.00	Medical Social Services	0	0		0	0		10. 00
11.00	Spiritual Counseling	0	0		0	0		11. 00
12.00	Di etary Counseling	0	0		0	0		12. 00
13.00	Counseling - Other	0	0		0	0		13.00
14.00	Home Health Aide and Homemaker	0	0		0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0		15. 00
16.00	Other	0	0		0	0		16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	0		17. 00
18. 00	Anal gesi cs	0	0		0	0		18. 00
19. 00	Sedatives / Hypnotics	0	0		0	0		19. 00
20.00	Other - Specify	0	0		0	0		20. 00
21.00	Durable Medical Equipment/Oxygen	0	0		0	0		21. 00
22. 00	Patient Transportation	0	0		0	0		22. 00
23.00	I maging Services	0	0		0	0		23. 00
24.00	Labs and Diagnostics	0	0		0	0		24. 00
25.00	Medical Supplies	0	0		0	0		25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0		0	0		26. 00
27.00	Radiation Therapy	0	0		0	0		27. 00
28. 00	Chemotherapy	0	0		0	0		28. 00
29. 00	Other	0	0		0	0		29. 00
30.00	Bereavement Program Costs	0	0		0	0		30. 00
31.00	Volunteer Program Costs	0	0		0	0		31. 00
32.00	Fundrai si ng	0	0		0	0		32. 00
33.00	Other Program Costs	0	0		0	0		33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	11, 682		0	16		34. 00
35.00	Total cost to be allocated	0	2, 680		0	10, 881		35. 00
36. 00	Unit Cost Multiplier (see instructions)	0. 000000	0. 229413	0.0000	000	680. 062500		36. 00

Heal th	Financial Systems	ENRY COUNTY MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF TOTAL HOSPICE SHARED COSTS		Provi der Co	CN: 15-0030	Peri od:	Worksheet K-5	
			Hospi ce CCI	N: 15-1564	From 01/01/2015 To 12/31/2015		narod:
			nospi ce cci	N. 13-1304	10 12/31/2013	2/15/2017 2:1	
					Hospi ce I		<u> </u>
	Cost Center Description	Wk	st. C, Part	Cost to Char	ge Total Hospice	Hospi ce Shared	
		1	, col . 11	Ratio	Charges	Anci I I ary	
			line			Costs (cols. 1	
					Records)	x 2)	
			0	1. 00	2. 00	3. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY		66.00	l .	74 0	0	1.00
2.00	OCCUPATI ONAL THERAPY		67. 00	l .			2. 00
3.00	SPEECH PATHOLOGY		68. 00	l .	61 0	0	3. 00
4.00	DRUGS CHARGED TO PATIENTS		73. 00	l .	20 0	0	4. 00
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00	l .			5. 00
6.00	LABORATORY		60.00	l .		0	6. 00
6. 01	BLOOD LABORATORY		60. 01	l .		0	6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71. 00	l .	32 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. 7863	52 0	0	10.00
11. 00	Totals (sum of lines 1-10)					0	11. 00

Heal th	Financial Systems HENRY COUNTY MEN	IORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF HOSPICE PER DIEM COST	Provider CO	CN: 15-0030	Peri od:	Worksheet K-6	
		Hospi ce CCN	N: 15-1564	From 01/01/2015 To 12/31/2015		
				Hospi ce I		
		Title XVIII	Title XIX	Other	Total	
		1.00	2. 00	3. 00	4. 00	
1.00	Total cost (see instructions)				1, 120, 037	1. 00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				6, 217	2. 00
3.00	Average cost per diem (line 1 divided by line 2)				180. 16	3. 00
4. 00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	5, 719				4. 00
5.00	Aggregate Medicare cost (line 3 time line 4)	1, 030, 335				5. 00
6. 00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		1:	20		6. 00
7.00	Aggregate Medicaid cost (line 3 time line 60)		21, 6	19		7. 00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	3, 100				8. 00
9.00	Aggregate SNF cost (line 3 time line 8)	558, 496				9. 00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)			0		10.00
11.00	Aggregate NF cost (line 3 times line 10)			0		11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			378		12. 00
13. 00	Aggregate cost for other days (line 3 times line 12)			68, 100		13. 00

CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0030	Peri od: From 01/01/2015 To 12/31/2015		
		Title XVIII	Hospi tal	PPS	
	DART I FILLY PROCEETIVE HETURE			1. 00	
	PART I - FULLY PROSPECTIVE METHOD				-
1. 00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			648, 100	1.00
1. 00	Model 4 BPCI Capital DRG other than outlier			046, 100	1. 00
2.00	Capital DRG outlier payments			19, 104	
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 reporting period (see ins	tructions)	20. 55	
4.00	Number of interns & residents (see instructions)	3 1 1	,	0.00	4.00
5.00	Indirect medical education percentage (see instructions	s)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5	by the sum of lines 1 and 1.0	1, columns 1 and	0	6.00
	1.01)(see instructions)				
7.00	Percentage of SSI recipient patient days to Medicare Pa	art A patient days (Worksheet I	E, part A line	0.00	7. 00
0.00	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see	Instructions)		0.00	
9. 00 10. 00	Sum of lines 7 and 8	ictions)		0. 00 0. 00	
11. 00	Allowable disproportionate share percentage (see instru Disproportionate share adjustment (see instructions)	ictions)		0.00	11.00
12. 00	Total prospective capital payments (see instructions)			667, 204	
12.00	Total prospective capital payments (see That detrois)			007, 204	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instruction			0	1.00
2.00	Program inpatient ancillary capital cost (see instructi			0	
3.00	Total inpatient program capital cost (line 1 plus line	2)		0	3.00
4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	4. 00 5. 00
3.00	Total Tipatient program capital cost (Time 3 x Time 4)			U	3.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
	Program inpatient capital costs (see instructions)			0	1.00
1.00					
2.00	Program inpatient capital costs for extraordinary circu			0	2.00
2. 00 3. 00	Program inpatient capital costs for extraordinary circu Net program inpatient capital costs (line 1 minus line			0	2. 00 3. 00
2.00 3.00 4.00	Program inpatient capital costs for extraordinary circu Net program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions)	2)		0 0.00	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs for extraordinary circu Net program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line	2)		0 0.00 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient capital costs for extraordinary circunstance in patient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances of the comparison of the comparison comparison comparison to payments (line 3 x line percentage adjustment for extraordinary circumstances)	2) 4) (see instructions)	(line 6)	0 0.00 0 0.00	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient capital costs for extraordinary circunstance in patient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances adjustment to capital minimum payment level for extraordinary circumstances and payment to capital minimum payment level for extraordinary circumstances.	2) 4) (see instructions)	αline 6)	0 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient capital costs for extraordinary circuments program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances (Adjustment to capital minimum payment level for extraordinary circumstances) Capital minimum payment level for extraordinary circumstances (Line 5 plus line 7)	4) (see instructions) rdinary circumstances (line 2)	κline 6)	0.00 0.00 0.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Program inpatient capital costs for extraordinary circuments program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances and ustment to capital minimum payment level for extraordinary circumstances (Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as	4) (see instructions) rdinary circumstances (line 2 :	,	0. 00 0. 00 0. 00 0. 00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Program inpatient capital costs for extraordinary circuments program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances (Adjustment to capital minimum payment level for extraordial minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level	4) (see instructions) rdinary circumstances (line 2 : s applicable) el to capital payments (line 8	less line 9)	0.00 0.00 0.00 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Program inpatient capital costs for extraordinary circuments program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances and instructions) Adjustment to capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level	2) 4) (see instructions) rdinary circumstances (line 2 : s applicable) el to capital payments (line 8 over capital payment (from pri	less line 9) or year	0.00 0.00 0.00 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs for extraordinary circuments program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances (Adjustment to capital minimum payment level for extraor Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level Worksheet L, Part III, line 14)	4) (see instructions) rdinary circumstances (line 2 : s applicable) el to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus lin	less line 9) or year ne 11)	0.00 0.00 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Program inpatient capital costs for extraordinary circumset program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances adjustment to capital minimum payment level for extraordinary circumstances (apital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level (arryover of accumulated capital minimum payment level (by Carryover of accumulated capital minimum payment level (current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level	4) (see instructions) rdinary circumstances (line 2 : s applicable) el to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus line over capital payment for the sover capital payment for	less line 9) or year ne 11)	0.00 0.00 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 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	Program inpatient capital costs for extraordinary circumset program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances (Adjustment to capital minimum payment level for extraordinary circumstances) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital minimum payment level current year exception payment (if line 12 is positive,	4) (see instructions) rdinary circumstances (line 2 x s applicable) el to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus line enter the amount on this line over capital payment for the second control of the	less line 9) or year ne 11)	0.00 0.00 0.00 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)

15.00 0 16. 00 0 17. 00