This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0005 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/31/2023 12:20 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/31/2023 Time: 12:20 pm Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HENDRICKS REGIONAL HEALTH (15-0005) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

	·		Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	639, 553	27, 017	0	-728, 579	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	TOTAL	0	639, 553	27, 017	0	-728, 579	200.00
	NIVIAL	U					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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/31/2023 12:20 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1000 EAST MAIN STREET 1.00 PO Box: 1.00 State: IN Zip Code: 46122-1409 County: HENDRICKS 2.00 City: DANVILLE 2.00 Provi der Component Name CCN CBSA Date Payment System (P, T, 0, or N)
V | XVIII | XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 HENDRICKS REGIONAL 150005 26900 07/01/1966 Ν 3.00 HFAI TH Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15 00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 9 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October

1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires a final UCP 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 in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.

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22.03

22 04

23.00

Ν

22.03 Did this hospital receive a geographic reclassification from urban to

22.04 Did this hospital receive a geographic reclassification from urban to

yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25

rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

yes or "N" for no.

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/31/2023 12:20 pm In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 655 348 4,013 0 24 00 0 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν N Ν 48.00 Teachi ng Hospi tal s Is this a hospital involved in training residents in approved GME programs? For cost reporting Ν 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of

which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/31/2023 12: 20 pm XVIII XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 Υ instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If line 60 is yes, complete columns 2 and 3 for each program. (see 60.01 23 00 1 instructions) Y/N LME Direct GME IME Direct GME 1.00 2.00 3.00 4. 00 5. 00 61.00 Did your hospital receive FTE slots under ACA 0 00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)
61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ahted Unwei ahted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 61.20 0.00 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 N

"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	HENDRI C	KS REGIONAL HEALTH		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provider CC		eriod: fom 01/01/2022 o 12/31/2022	Worksheet S-2 Part I Date/Time Pre 5/31/2023 12:	pared:
			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col . 2))	
			Si te 1.00	2. 00	3. 00	
Section 5504 of the ACA Base Yea	r FTE Residents in N	onprovider Settings				
period that begins on or after of the following seriod that begins on or after of the following seriod the following seriod the following seriod that the following seriod	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.00	
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Si te	nospi tai	COI: 477	
(F 00 Fatar in advant 1   if line (2)	1. 00	2. 00	3. 00	4. 00	5. 00	/F 00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00		65.00
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col . 2))	
			Si te 1.00	2. 00	3. 00	
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Setting				
beginning on or after July 1, 20		mu aana maal dant	0.00	0.00	0.000000	44 00
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column :	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
47 00 l5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1. 00	2.00	3.00	4. 00	5.00	/=
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0. 000000	67.00

10SPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	CCN: 15-0005	Period: From 01/01/ To 12/31/	2022 F 2022 E	Workshee Part I Date/Tir 5/31/202	ne Pre	pared:	
					1.00	0		
68. 00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065- For a cost reporting period beginning prior to October 1, 2022, did you MAC to apply the new DGME formula in accordance with the FY 2023 IPPS F (August 10, 2022)?	obtain permis	ssion from yo		N		68. 00	
			-	1. 00	2.00	3. 00		
70.00	Inpatient Psychiatric Facility PPS	-t-: IDE -					70.00	
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it co Enter "Y" for yes or "N" for no.  If line 70 is yes: Column 1: Did the facility have an approved GME teac recent cost report filed on or before November 15, 2004? Enter "Y" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residen program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for Column 3: If column 2 is Y, indicate which program year began during th (see instructions)	hing program i yes or "N" fo ts in a new to yes or "N" fo	n the most or no. (see eaching or no.	N N	N	0	70.00	
75. 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it	contain an II	RF	N			75. 00	
76. 00	subprovider? Enter "Y" for yes and "N" for no.  If line 75 is yes: Column 1: Did the facility have an approved GME teac recent cost reporting period ending on or before November 15, 2004? Ent no. Column 2: Did this facility train residents in a new teaching progr CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: indicate which program year began during this cost reporting period. (s	er "Y" for yes am in accordan If column 2 is	s or "N" for nce with 42 s Y,	N	N	0	76. 00	
					1.00	0		
30. 00 31. 00	Long Term Care Hospital PPS 0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 1.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Ente "Y" for yes and "N" for no.							
35. 00 36. 00	no.	N		85. 00 86. 00				
37. 00	\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classifie $1886(d)(1)(B)(vi)$ ? Enter "Y" for yes or "N" for no.	d under sectio	on		N		87. 00	
			Approved Permane Adjustme (Y/N)	nt ent	Number Approv Perman Adjustm	ved ent ents		
38. 00	Column 1: Is this hospital approved for a permanent adjustment to the T amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete 89. (see instructions)		1.00 ne		2. 00		88. 00	
	Column 2: Enter the number of approved permanent adjustments.	Wkst. A Li	ne Effecti	ve	Appro	ved		
		No.	Date		Perman Adjustr Amount Discha	ment Per		
39. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2. 00		3. 00		89. 00	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.  Column 3: Enter the amount of the approved permanent adjustment to the					J	071.00	
	TEFRA target amount per discharge.				VI.)	,		
			1. 00		XI X 2. 00			
90.00	Title V and XIX Services  Does this facility have title V and/or XIX inpatient hospital services?	Enter "Y" for	- N		Υ		90.00	
91. 00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost rep		N		Υ		91. 00	
92. 00	full or in part? Enter "Y" for yes or "N" for no in the applicable colu Are title XIX NF patients occupying title XVIII SNF beds (dual certific				N		92.00	
93. 00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V	and XIX? Enter	- N		N		93. 00	
94. 00	"Y" for yes or "N" for no in the applicable column.  Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for	no in the	N		N		94. 00	
	applicable column.  If line 94 is "Y", enter the reduction percentage in the applicable col	umn.	0.00		0.00	0	95.00	
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for applicable column.		N		N		96.00	

		eri od:	wof Form CMS- Worksheet S-	
		rom 01/01/2022 o 12/31/2022	Part I Date/Time Pr	epared:
		V	5/31/2023 12	
		1.00	2. 00	+
8.00 Does title V or XIX follow Medicare (title XVIII) for the interns and restepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N column 1 for title V, and in column 2 for title XIX.		Y	Y	98. 0
8.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and i		Y	Y	98.0
title XIX.  3.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no		Y	Y	98. 0
for title V, and in column 2 for title XIX.  3.03 Does title V or XIX follow Medicare (title XVIII) for a critical access reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for		N	N	98.0
for title V, and in column 2 for title XIX.  Boes title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 1 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for a column 2 for title XIX.		N	N	98.0
in column 2 for title XIX.  B.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE of Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for		Y	Y	98.0
column 2 for title XIX.  8.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed f Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title column 2 for title XIX.		Y	Y	98.0
Rural Providers				
O5.00 Does this hospital qualify as a CAH? O6.00 If this facility qualifies as a CAH, has it elected the all-inclusive me for outpatient services? (see instructions)	thod of payment	N N		105. C
07.00 Column 1: If line 105 is Y, is this facility eligible for cost reimburse training programs? Enter "Y" for yes or "N" for no in column 1. (see in Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train 18	nstructions) aRs in an	N		107.0
approved medical education program in the CAH's excluded IPF and/or IRF Enter "Y" for yes or "N" for no in column 2. (see instructions)  08.00 Is this a rural hospital qualifying for an exception to the CRNA fee sch  CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108. (
Physi cal Physi cal	Occupati onal	Speech	Respi ratory	
09.00 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.	2. 00 N	3. 00 N	4. 00 N	109.0
Tot you of it for no for each therapy.				
10.00Did this hospital participate in the Rural Community Hospital Demonstrat	ion project (8/	1104	1.00 N	110.0
Demonstration) for the current cost reporting period? Enter "Y" for yes complete Worksheet E, Part A, Lines 200 through 218, and Worksheet E-2, applicable.	or "N" for no. I	f yes,	14	110.0
		1.00	2. 00	-
11.00   If this facility qualifies as a CAH, did it participate in the Frontier   Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y,	period? Enter	N N	2.00	111.0
integration prong of the FCHIP demo in which this CAH is participating i Enter all that apply: "A" for Ambulance services; "B" for additional bed for tele-health services.	n column 2.			
	1.00	2. 00	3. 00	-
12.00Did this hospital participate in the Pennsylvania Rural Health Model	N	2.00	0.00	112.0
(PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is				
"Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.				113. 0
"Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased				
"Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  13.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.  Miscellaneous Cost Reporting Information	N			0115 (
"Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  13.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.  Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on	N			0115. C
"Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  13.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.  Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				0115. C
"Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  13.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.  Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on				

Health Financial Systems	HENDRICKS REGION	IAL HEALTH		In Lie	ı of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE		Provi der CC		Peri od: From 01/01/2022	Worksheet S Part I	
				To 12/31/2022	Date/Time F	
			Premi ums	Losses	5/31/2023 1 I nsurance	
110 Olli et empunto ef mel presti ce premiumo errori	ad polid Loopes		1.00	2.00	3. 00	0110 01
118.01 List amounts of malpractice premiums ar	iu paru rosses:		2, 363, 59	97		0118.01
118.02 Are mal practice premiums and paid losse	os reported in a cost o	ontor other t	than the	1. 00 N	2. 00	118. 02
Administrative and General? If yes, su and amounts contained therein.				IN		110.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for \$3121 and applicable amendments? (see i "N" for no. Is this a rural hospital wi Hold Harmless provision in ACA \$3121 ar	nstructions) Enter in th < 100 beds that quand applicable amendment	column 1, "Y' Hifies for th	" for yes or he Outpatient		N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" 1 121.00 Did this facility incur and report cost patients? Enter "Y" for yes or "N" for	ts for high cost implan	itable devices	s charged to	Y		121. 00
122.00 Does the cost report contain healthcare Act?Enter "Y" for yes or "N" for no in	e related taxes as defi				5. 00	122. 00
the Worksheet A line number where these 123.00 Did the facility and/or its subprovider services, e.g., legal, accounting, tax management/consulting services, from ar for yes or "N" for no.	rs (if applicable) purc preparation, bookkeepi n unrelated organizatio	ng, payroll, on? In column	and/or 1, enter "Y"			123. 00
If column 1 is "Y", were the majority of professional services expenses, for ser located in a CBSA outside of the main has "N" for no.	rvices purchased from unospital CBSA? In colum	inrelated orga	ani zati ons			
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-c		nter? Enter '	"Y" for yes	N		125. 00
and "N" for no. If yes, enter certifica 126.00   f this is a Medicare-certified kidney			ification dat	te		126. 00
in column 1 and termination date, if and 127.00 If this is a Medicare-certified heart 1	oplicable, in column 2.					127. 00
in column 1 and termination date, if ap 128.00 If this is a Medicare-certified liver 1	oplicable, in column 2.					128. 00
in column 1 and termination date, if and 129.00 If this is a Medicare-certified lung to	ransplant program, ente	r the certifi	ication date			129. 00
in column 1 and termination date, if as 130.00 If this is a Medicare-certified pancrea date in column 1 and termination date,	s transplant program,	enter the cer	rtification			130. 00
131.00 If this is a Medicare-certified intesti date in column 1 and termination date,	nal transplant program	, enter the d	certi fi cati or	ı		131. 00
132.00 If this is a Medicare-certified islet to in column 1 and termination date, if a	transplant program, ent	er the certif	fication date	9		132. 00
133.00 Removed and reserved 134.00 If this is a hospital-based organ procuin column 1 and termination date, if a		PO), enter th	he OPO number	-		133. 00 134. 00
All Providers  140.00 Are there any related organization or h	nome office costs as do	fined in CMS	Dub 15 1	N		140. 00
chapter 10? Enter "Y" for yes or "N" for are claimed, enter in column 2 the home	or no in column 1. If y	es, and home	office costs			140.00
1.00 If this facility is part of a chain org	2.00	nes 141 thro	uah 143 the i	3.00	of the home	2
office and enter the home office contra	actor name and contract				or the nome	
	Contractor's Name: PO Box:		Contracto	or's Number:		141. 00 142. 00
	State:		Zi p Code:	:		143. 00
					1. 00	
144.00 Are provider based physicians' costs in	ncluded in Worksheet A?				Y	144. 00
				1. 00	2. 00	
145.00 If costs for renal services are claimed inpatient services only? Enter "Y" for no, does the dialysis facility include	yes or "N" for no in c Medicare utilization f	olumn 1. If o	column 1 is	Y		145. 00
period? Enter "Y" for yes or "N" for r 146.00Has the cost allocation methodology cha Enter "Y" for yes or "N" for no in colu	anged from the previous			N		146. 00
yes, enter the approval date (mm/dd/yyy		•	•			

Health Financial Systems	HENDRI CKS	REGION	NAL HEALTH			In Lie	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	A	Provi der CC	CN: 15-0005		riod: om 01/01/2022 12/31/2022		epared:
							1.00	-
147.00 Was there a change in the statist	ical basis? Enter "V"	for ve	es or "N" for	· no			1.00 N	147. 00
148.00Was there a change in the order of							N N	148. 00
149.00 Was there a change to the simplif					for n	10.	N N	149.00
			Part A	Part		Title V	Title XIX	
			1.00	2. 00		3. 00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or								
155. 00 Hospi tal			N	N		N	N	155. 00
156.00 Subprovi der - IPF			N	N		N	N	156. 00
157.00 Subprovi der - I RF			N	N		N	N	157. 00
158. 00 SUBPROVI DER								158.00
159. 00 SNF			N	N N		N	N	159.00
160.00HOME HEALTH AGENCY 161.00CMHC			N	N N	-	N N	N N	160. 00 161. 00
TO T. OU CWINC				IV		IN		161.00
Multicampus							1. 00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one	or more camp	uses in di	i ffere	ent CBSAs?	N	165. 00
Effect 1 For yes of 10 For He.	Name		County	State	Zip	Code CBSA	FTE/Campus	
	0		1. 00	2.00	3. 0		5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.0	166. 00
							1.00	
Health Information Technology (HI						Act		
167.00 s this provider a meaningful use 168.00 of this provider is a CAH (line 10 reasonable cost incurred for the	05 is "Y") and is a me	eani ngf	ful user (lin			enter the	N	167. 00 168. 00
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user,	, does	this provide			hardshi p		168. 01
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y")					l"), enter the	0.0	00169.00
						Begi nni ng	Endi ng	
						1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and end	di ng da	ate for the r	eporti ng				170. 00
						1. 00	2.00	
171.00 ffline 167 is "Y", does this prosection 1876 Medicare cost plans "Y" for yes and "N" for no in column 1876 Medicare days in column 2.	reported on Wkst. S-3, umn 1. If column 1 is	, Pt. I	, line 2, co	I. 6? Ente		N		0171.00

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/31/2023 12:20 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column  $\hat{\textbf{3}},$  "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 05/21/2021 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Y/N Legal Oper. 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Υ 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Υ 03/08/2023 Υ 03/08/2023 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for 17.00 N N 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 18.00 N N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

	Financial Systems HENDRICKS REGI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0005	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre			
	·				5/31/2023 12:	20 pm		
			ption	Y/N	Y/N			
20.00	16 line 1/ on 17 in the many office treath and to DC0D	(	)	1.00	3.00	20.00		
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		
	Report data for other: bescribe the other adjustments.	Y/N	Date	Y/N	Date			
		1.00	2.00	3. 00	4. 00			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00		
	COMPLETED BY COOK DELINDINGED AND TEEDA HOODITALO ONLY (EVO	EDT ALL LEBENA	10001 TALO		1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS I	HOSPITALS)			-		
22 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	o instructions			N	22.00		
22. 00 23. 00	Have changes occurred in the Medicare depreciation expense		sals mada du	ring the cost	N N	23.00		
23.00	reporting period? If yes, see instructions.	due to apprais	sai s illade du	iring the cost	IV	23.00		
24. 00								
25. 00	Have there been new capitalized leases entered into during	the cost repor	rting period	? If yes, see	N	25.00		
	i nstructi ons.	·	- *	-				
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost report	ing period?	lf yes, see	N	26.00		
07.00	instructions.			6		07.00		
27. 00	Has the provider's capitalization policy changed during the	e cost reportii	ng period?i	r yes, submit	N	27.00		
	copy. Interest Expense							
28. 00	Were new Loans, mortgage agreements or Letters of credit e	ntered into du	ring the cos	t reporting	N	28.00		
20.00	period? If yes, see instructions.		ing the eee	t roportring		20.0		
29. 00	Did the provider have a funded depreciation account and/or	bond funds (De	ebt Service	Reserve Fund)	N	29.00		
	treated as a funded depreciation account? If yes, see inst	ructi ons		, i				
30. 00	Has existing debt been replaced prior to its scheduled mate	urity with new	debt? If ye	s, see	N	30.00		
31. 00								
	instructions. Purchased Services							
32. 00	Have changes or new agreements occurred in patient care se	rvi ces furni sh	ed through c	ontractual	N	32.00		
	arrangements with suppliers of services? If yes, see instru							
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 app	plied pertaini	ng to compet	itive bidding? If	N	33.0		
	no, see instructions.			_				
	Provi der-Based Physi ci ans							
34. 00	Were services furnished at the provider facility under an a	arrangement wi	th provider-	based physicians?	' N	34.00		
25 00	If yes, see instructions.		-4! 41- 41		N.	25 00		
35. 00	If I ine 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in	rstructions	nts with the	provi der-based	N	35.0		
	priysicians during the cost reporting period: if yes, see if	iisti ucti olis.		Y/N	Date			
				1.00	2. 00			
	lu anni							
	Home Office Costs							
36. 00				N		36.00		
	Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	home office					
37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pull fyes, see instructions.			? N		37.00		
37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pulf yes, see instructions. If line 36 is yes, was the fiscal year end of the home of	fice different	from that o	? N		37.00		
37. 00 38. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pullifyes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end	fice different d of the home (	from that o office.	? N f N		37.00		
37. 00 38. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been put figures, see instructions. If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end of the provider? If yes, enter in column 2 the fiscal year end of the provider?	fice different d of the home (	from that o office.	? N f N		37.00		
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been put yes, see instructions. If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end of the year, and the provider render services to other see instructions.	fice different d of the home o er chain compon	from that o office. nents? If ye	? N f N s, N		37. 00 38. 00 39. 00		
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been put yes, see instructions.  If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end if line 36 is yes, did the provider render services to other see instructions.  If line 36 is yes, did the provider render services to the	fice different d of the home o er chain compon	from that o office. nents? If ye	? N f N s, N		37. 00 38. 00 39. 00		
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been put yes, see instructions. If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end of the year, and the provider render services to other see instructions.	fice different d of the home o er chain compon	from that o office. nents? If ye	? N f N s, N		37. 00 38. 00 39. 00		
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been put yes, see instructions.  If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end if line 36 is yes, did the provider render services to other see instructions.  If line 36 is yes, did the provider render services to the	fice different d of the home o er chain compon home office?	from that o office. nents? If ye	? N f N s, N	00	37. 00 38. 00 39. 00		
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been put yes, see instructions.  If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end of the provider? If yes, enter in column 2 the fiscal year end in a 36 is yes, did the provider render services to other see instructions.  If line 36 is yes, did the provider render services to the instructions.  Cost Report Preparer Contact Information	fice different d of the home of er chain compos home office?	from that o office. nents? If ye If yes, see	? N f N s, N N	00	37. 00 38. 00 39. 00		
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been put yes, see instructions.  If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end of the provider year end. If line 36 is yes, did the provider render services to other see instructions.  If line 36 is yes, did the provider render services to the instructions.  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position	fice different d of the home o er chain compon home office?	from that o office. nents? If ye If yes, see	? N f N s, N	00	36. 00 37. 00 38. 00 39. 00 40. 00		
37. 00 38. 00 39. 00 40. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been put yes, see instructions.  If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end lf line 36 is yes, did the provider render services to other see instructions.  If line 36 is yes, did the provider render services to the instructions.  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	fice different d of the home of er chain compos home office?	from that o office. nents? If ye If yes, see	? N f N s, N N	00	37. 00 38. 00 39. 00 40. 00		
37. 00 38. 00 39. 00 40. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been put yes, see instructions.  If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end of the home of the provider in the fiscal year end.  If line 36 is yes, did the provider render services to the instructions.  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	fice different d of the home of er chain compon home office?	from that o office. nents? If ye If yes, see	? N f N s, N N	00	37. 00 38. 00 39. 00 40. 00		
37. 00 38. 00 39. 00 40. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been put fighter. If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end if line 36 is yes, did the provider render services to other see instructions.  If line 36 is yes, did the provider render services to the instructions.  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report	fice different d of the home of er chain compos home office?	from that o office. nents? If ye If yes, see	? N f N s, N N	00	37. 00 38. 00 39. 00 40. 00		
37. 00 38. 00 39. 00 40. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been put yes, see instructions.  If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end of the provider? If yes, enter in column 2 the fiscal year end of the provider in the fiscal year end of the provider services to other see instructions.  If line 36 is yes, did the provider render services to the instructions.  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report preparer.	fice different d of the home of er chain compon home office?	from that o office. nents? If ye If yes, see	? N f N s, N N		37. 00 38. 00 39. 00 40. 00		

Heal th Fi	inancial Systems	HENDRICKS REGI	ONAL HEALTH		In Lieu of Form CMS-2552-10			
HOSPI TAL	. AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-0005	Peri From To	01/01/2022	Worksheet S-2 Part II Date/Time Pre 5/31/2023 12:	pared:
		-		3. 00	+			
Co	ost Report Preparer Contact Information							
	nter the first name, last name and the ti		OI RECTOR					41.00
	eld by the cost report preparer in columr	ns 1, 2, and 3,						
	especti vel y.							
42. 00 Er	nter the employer/company name of the cos	st report						42.00
	reparer.							
	nter the telephone number and email addre							43.00
re	eport preparer in columns 1 and 2, respec	cti vel y.						

 
 Health Financial Systems
 HENDRICH

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-0005

				T	o 12/31/2022	Date/Time Pre 5/31/2023 12:	pared:
						1/P Days /	20 piii
						0/P Visits /	
						Tri ps	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	116	42, 340	0. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)						2. 00
3. 00	HMO IPF Subprovider						3.00
4. 00	HMO IRF Subprovider						4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		116	42, 340	0. 00	0	7. 00
	beds) (see instructions)			,		_	
8.00	INTENSIVE CARE UNIT	31.00	14	5, 110	0.00	0	8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43. 00				0	13.00
14.00	Total (see instructions)		130	47, 450	0. 00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVIDER - I RF						17.00
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY	44.00	0	0		0	18. 00 19. 00
20.00	NURSING FACILITY	44.00	٩	0		U	20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30.00					24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		130				27. 00
28. 00	Observation Bed Days					105	28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)		0	0			31. 00 32. 00
32. 00	Total ancillary labor & delivery room		Y	0			32. 00 32. 01
J∠. U I	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01
	Temporary Expansion COVID-19 PHE Acute Care	30.00	o	0		0	

 Health Financial Systems
 HENDRICH

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

				Т	o 12/31/2022	Date/Time Pre 5/31/2023 12:	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	20 piii
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA				ı	T	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	5, 810	480	18, 840			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)	4 7//	4 122				2 00
2.00	HMO and other (see instructions)	4, 766	4, 133				2. 00 3. 00
3. 00 4. 00	HMO IPF Subprovider HMO IRF Subprovider	0	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF		0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0				6.00
7. 00	Total Adults and Peds. (exclude observation	5, 810	480				7.00
7.00	beds) (see instructions)	3,010	400	10, 040			7.00
8. 00	INTENSIVE CARE UNIT	841	0	2, 693			8.00
9. 00	CORONARY CARE UNIT		ŭ	2,070			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		142	1, 906			13.00
14.00	Total (see instructions)	6, 651	622	23, 439	0.00	1, 867. 02	14.00
15.00	CAH visits	O	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			68			24. 10
25. 00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26. 00 26. 25
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	١	0	U	0. 00 0. 00		
28. 00	Observation Bed Days		105	4, 329		1,007.02	28.00
29.00	Ambul ance Trips	0	103	4, 327			29.00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days (see Thisti detroit)			Ö			31.00
32. 00	Labor & delivery days (see instructions)	0	261	589			32.00
32. 01	Total ancillary labor & delivery room		20.	0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33.00
33. 01	LTCH site neutral days and discharges	o					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	o	0	0			34.00

Provi der CCN: 15-0005

				To	12/31/2022	Date/Time Pre 5/31/2023 12:	
		Full Time		Di sch	arges	37 3 17 2023 12.	20 piii
		Equi val ents			_		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	11.00	Pati ents	
	DART I CTATICTICAL DATA	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 618	110	5, 791	1. 00
1.00	8 exclude Swing Bed, Observation Bed and		O	1,010	110	5, 771	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			889	972		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
8. 00	beds) (see instructions)						8. 00
9. 00	INTENSIVE CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	0	1, 618	110	5, 791	14.00
15.00	CAH visits						15.00
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY	0. 00					19.00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE						20. 00 21. 00
21.00	HOME HEALTH AGENCY						21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27.00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31. 00 32. 00
32.00	Labor & delivery days (see instructions)						32. 00 32. 01
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days			О			33. 00
33. 01	LTCH site neutral days and discharges			o o			33. 01
	Temporary Expansion COVID-19 PHE Acute Care						34.00
	· · · · · · · · · · · · · · · · · · ·	•		. '	,	'	•

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0005 Peri od: Worksheet S-3 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/31/2023 12:20 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Reported ion of Sal ari es Related to Sal ari es (col. 2 ± col. Salaries in (from Wkst 3) col 4 A-6)1.00 2.00 3.00 4.00 5.00 6.00 PART II - WAGE DATA SALARI ES 200 00 1.00 Total salaries (see 189, 134, 150 189, 134, 150 3, 883, 415. 00 48.70 1.00 instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3 00 O 0 00 3 00 Non-physician anesthetist Part 0 00 4.00 Physician-Part A -1, 369, 232 1, 369, 232 8, 581. 00 159.57 4.00 Administrative 4. 01 Physicians - Part A - Teaching 0.00 0.00 4.01 106, 494. 26 5.00 Physician and Non 18, 128, 319 18, 128, 319 170.23 5.00 Physician-Part B 6.00 Non-physician-Part B for 0 0.00 0.00 6.00 hospital-based RHC and FQHC servi ces Interns & residents (in an 7.00 7.00 21.00 0 0.00 0.00 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office and/or related 0 0.00 0.00 8.00 organization personnel 9 00 44.00 SNF 0.00 0 00 9 00 10.00 Excluded area salaries (see 67, 704, 161 176, 572 67, 880, 733 1, 120, 498. 00 60.58 10.00 instructions) OTHER WAGES & RELATED COSTS 4, 397, 407 118. 47 11.00 Contract labor: Direct Patient 4, 397, 407 37, 119. 01 11.00 Contract Labor: Top Level 0 12.00 0 0.00 0.00 12.00 management and other management and administrative servi ces 13.00 Contract Labor: Physician-Part 17,000 0 17,000 87.00 195. 40 13.00 A - Administrative 14.00 Home office and/or related 0 0 0.00 0.00 14.00 organization salaries and wage-related costs 14.01 Home office salaries 0 0.00 0.00 14.01 Related organization salaries 0.00 14.02 14.02 0 0.00 15.00 Home office: Physician Part A 0 0.00 0.00 15.00 - Administrative 0 16.00 Home office and Contract 0.00 0.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A O 0.00 0.00 16.01 - Teachi ng Home office contract 16.02 16.02 0 0.00 0.00 Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see 30, 762, 261 30, 762, 261 17.00 instructions) 18.00 Wage-related costs (other) 18 00 (see instructions) 19.00 Excluded areas 13, 994, 662 13, 994, 662 19.00 20.00 Non-physician anesthetist Part 20.00 21.00 Non-physician anesthetist Part 0 21.00 22.00 Physician Part A -161, 119 22.00 161, 119 Administrative 22.01 Physician Part A - Teaching 22.01 Physician Part B 2,043,403 2,043,403 23.00 23 00 24.00 Wage-related costs (RHC/FQHC) 24.00 0 25.00 Interns & residents (in an 0 0 25.00 approved program) 25.50 Home office wage-related C 0 25.50 (core) 25.51 Related organization 0 25.51 wage-related (core) Home office: Physician Part A 25.52 0 25.52

- Administrative wage-related (core) HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0005 Peri od: Worksheet S-3 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/31/2023 12:20 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of (col. 2 ± col. Sal ari es Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 0 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 3, 408, 754 -163, 708 3, 245, 046 78, 371. 00 41. 41 26.00 27.00 Administrative & General 5.00 15, 846, 016 207, 247 16, 053, 263 349, 484. 00 45. 93 27.00 28. 00 2, 324, 866 2, 324, 866 7, 064. 80 329. 08 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 2, 983, 696 2,630 2, 986, 326 99, 913. 00 29.89 30.00 Laundry & Linen Service 8.00 404, 899 405, 256 20, 265. 00 20.00 31.00 31.00 357 3, 277, 512 32.00 Housekeepi ng 2, 889 9.00 3, 280, 401 153, 324. 00 21. 40 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 2, 364, 000 -1, 754, 024 609, 976 25, 784. 00 23. 66 34.00 35.00 Dietary under contract (see  $\cap$ 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 1, 756, 108 1, 756, 108 74, 233. 00 23. 66 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 Nursing Administration 13.00 4, 374, 539 3, 856 85, 207. 00 51.39 38.00 38.00 4, 378, 395 39.00 Central Services and Supply 14.00 1, 233, 195 1,087 1, 234, 282 45, 790.00 26. 96 39.00 3, 119, 384 69, 830. 00 40.00 Pharmacy 15.00 3, 116, 637 2,747 44.67 40.00 Medical Records & Medical Records Library 41.00 16.00 450, 344 397 450, 741 18, 204. 00 24. 76 41. 00

2, 136, 265

1,883

2, 138, 148

53, 386. 00

0.00

40. 05 42. 00

0.00 43.00

17.00

18.00

42.00

Social Service

43.00 Other General Service

Health Financial Systems	inancial Systems HENDRICKS REGIONAL HEALTH In Lieu o				
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0005	Peri od: Worksheet S-3			

						rom 01/01/2022 o 12/31/2022		
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		173, 330, 697	0	173, 330, 697	3, 783, 985. 54	45. 81	1.00
	instructions)							
2.00	Excluded area salaries (see		67, 704, 161	176, 572	67, 880, 733	1, 120, 498. 00	60. 58	2.00
	instructions)							
3.00	Subtotal salaries (line 1		105, 626, 536	-176, 572	105, 449, 964	2, 663, 487. 54	39. 59	3.00
	minus line 2)							
4.00	Subtotal other wages & related		4, 414, 407	0	4, 414, 407	37, 206. 01	118. 65	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		30, 923, 380	0	30, 923, 380	0.00	29. 33	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		140, 964, 323	-176, 572	140, 787, 75	2, 700, 693. 55	52. 13	6.00
7.00	Total overhead cost (see		41, 920, 723	61, 469	41, 982, 192	1, 080, 855. 80	38. 84	7.00
	instructions)							
				•	•		·	

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0005	Period: Worksheet S-3 From 01/01/2022 Part IV To 12/31/2022 Date/Time Prepared:

	To 12/31/2022	Date/Time Pre 5/31/2023 12:	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	6, 682, 737	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	25, 432, 571	
8. 03	Health Insurance (Purchased)	0	
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	1, 476, 189	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	219, 056	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)	410, 049	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	81, 521	
15.00		722, 714	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumul ative portion)		
	TAXES		
		11, 778, 825	
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	0	
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. (se	<b>e</b> 0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	157, 782	
24. 00		46, 961, 444	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Pre	
			5/31/2023 12:	20 pm
Cost Center Description		Contract	Benefit Cost	
		Labor		

			5/31/2023 12:	20 pm
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	4, 397, 407	46, 961, 444	1.00
2.00	Hospi tal	4, 397, 407	46, 961, 444	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF			4.00
5.00	Subprovi der - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	0	8.00
9.00	NURSI NG FACI LI TY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospi tal -Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D. P. ) I			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18. 00	Other	0	0	18.00

	Financial Systems HENDRICKS REGIONAL HEAL  AL UNCOMPENSATED AND INDIGENT CARE DATA Provid	er CCN: 15-0005	Peri od:	wof Form CMS-2 Worksheet S-1	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/31/2023 12:	pare 20 p
				1. 00	
	Uncompensated and indigent care cost computation			1.00	
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	by line 202 col	umn 8)	0. 237613	1.
	Medicaid (see instructions for each line)	-	,		
00	Net revenue from Medicaid			1, 567, 211	2.
00	Did you receive DSH or supplemental payments from Medicaid?			Y	3
00	If line 3 is yes, does line 2 include all DSH and/or supplemental pa		li cai d?	N	4
00	If line 4 is no, then enter DSH and/or supplemental payments from Me	di cai d		3, 755, 582	
00 00	Medicaid charges Medicaid cost (line 1 times line 6)			108, 221, 008 25, 714, 718	
00	Difference between net revenue and costs for Medicaid program (line	7 minus sum of	lines 2 and 5 if		
00	<pre>&lt; zero then enter zero)</pre>	mirius sum or	Trines 2 and 0, 11	20, 071, 720	0.
	Children's Health Insurance Program (CHIP) (see instructions for eac	n line)			
00	Net revenue from stand-alone CHIP			0	9.
. 00	Stand-al one CHIP charges			0	1
. 00	Stand-alone CHIP cost (line 1 times line 10)	11	) (6 the	0	11
. 00	Difference between net revenue and costs for stand-alone CHIP (line enter zero)	II minus iine 9	; if < zero then	0	12
	Other state or local government indigent care program (see instructi	ons for each li	ne)		ł
. 00	Net revenue from state or local indigent care program (Not included			0	13
. 00	Charges for patients covered under state or local indigent care prog		,	0	1
	10)				
. 00	State or local indigent care program cost (line 1 times line 14)			0	
. 00	Difference between net revenue and costs for state or local indigent	care program (	line 15 minus line	0	16
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and	state/local in	ndigent care progra	ams (see	1
	instructions for each line)	State/Tocal II	iai gent care progre	3113 (300	
. 00				0	
	Government grants, appropriations or transfers for support of hospit		(	0	
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indi 8, 12 and 16)	gent care progr	ams (sum of lines	20, 391, 925	19.
	,	Uni nsure	ed Insured	Total (col. 1	
			s patients		
		patient		+ col . 2)	
	Uncompensated Care (see instructions for each line)	1. 00	2.00	+ col . 2) 3.00	
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility	1.00	2.00	3.00	20.
0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions)		2.00	3.00	20
	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (	1. 00 8, 639	2. 00	3. 00	
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions)	1.00 8,639 see 2,052	2. 00 . 564 3, 445, 924 . 873 3, 445, 924	3. 00 12, 085, 488 5, 498, 797	21.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a	1.00 8,639 see 2,052	2. 00	3. 00 12, 085, 488 5, 498, 797	21.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care	1.00 8,639 see 2,052	2.00 .564 3,445,924 .873 3,445,924 0 0	3. 00 12, 085, 488 5, 498, 797	21.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care	1.00 8,639 see 2,052	2.00 .564 3,445,924 .873 3,445,924 0 0	3. 00 12, 085, 488 5, 498, 797	21.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care	1.00 8,639 see 2,052	2.00 .564 3,445,924 .873 3,445,924 0 0	3. 00 12, 085, 488 5, 498, 797	21.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day	1.00 8,639 See 2,052 5 2,052 s beyond a leng	2.00 3,445,924 0 0 873 3,445,924 0 3,445,924	3. 00 12, 085, 488 5, 498, 797 0 5, 498, 797	21. 22. 23.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progr	1.00  8, 639  2, 052  2, 052  s beyond a lengam?	2.00 .564 3,445,924 .873 3,445,924 0 0 .873 3,445,924 gth of stay limit	3. 00 12, 085, 488 5, 498, 797 0 5, 498, 797 1. 00 N	21. 22. 23.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progrif line 24 is yes, enter the charges for patient days beyond the indigent care.	1.00  8, 639  2, 052  2, 052  s beyond a lengam?	2.00 .564 3,445,924 .873 3,445,924 0 0 .873 3,445,924 gth of stay limit	3. 00 12, 085, 488 5, 498, 797 0 5, 498, 797 1. 00 N	21. 22. 23. 24.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prografiline 24 is yes, enter the charges for patient days beyond the indistay limit	1.00  8,639  2,052  2,052  s beyond a lengam? gent care prog	2.00 .564 3,445,924 .873 3,445,924 0 0 .873 3,445,924 gth of stay limit	3. 00 12, 085, 488 5, 498, 797 0 5, 498, 797 1. 00 N	21. 22. 23. 24. 25.
. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progr If line 24 is yes, enter the charges for patient days beyond the ind stay limit Total bad debt expense for the entire hospital complex (see instruct	1.00  8,639  2,052  2,052  s beyond a lengam? gent care progons)	2.00 .564 3,445,924 .873 3,445,924 0 0 .873 3,445,924 gth of stay limit	3. 00 12, 085, 488 5, 498, 797 0 5, 498, 797 1. 00 N	21. 22. 23. 24. 25. 26.
. 00 2. 00 3. 00 4. 00 5. 00 7. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progr If line 24 is yes, enter the charges for patient days beyond the ind stay limit Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see	see 2,052  2,052  s beyond a lengam? gent care progons) instructions)	2.00 .564 3,445,924 .873 3,445,924 0 0 .873 3,445,924 gth of stay limit	3. 00 12, 085, 488 5, 498, 797 0 5, 498, 797 1. 00 N 0 6, 667, 741 142, 235	21. 22. 23. 24. 25. 26. 27.
2. 00 2. 00 3. 00 4. 00 5. 00 7. 00 7. 01	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progr If line 24 is yes, enter the charges for patient days beyond the ind stay limit Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see in	see 2,052  2,052  s beyond a lengam? gent care progons) instructions)	2.00 .564 3,445,924 .873 3,445,924 0 0 .873 3,445,924 gth of stay limit	3. 00  12, 085, 488  5, 498, 797  0  5, 498, 797  1. 00  N  0  6, 667, 741  142, 235  218, 823	21. 22. 23. 24. 25. 26. 27. 27.
1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 7. 01 3. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progr If line 24 is yes, enter the charges for patient days beyond the ind stay limit Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see	see 2,052 2,052 s beyond a lengem? gent care progons) instructions)	2.00 3,445,924 873 3,445,924 0 0 873 3,445,924 9th of stay limit gram's length of	3. 00 12, 085, 488 5, 498, 797 0 5, 498, 797 1. 00 N 0 6, 667, 741 142, 235	21. 22. 23. 24. 25. 26. 27. 27. 28.
1. 00 2. 00 4. 00 5. 00 5. 00 7. 00 7. 01 3. 00 9. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (instructions) Payments received from patients for amounts previously written off a charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progr If line 24 is yes, enter the charges for patient days beyond the ind stay limit Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see in Non-Medicare bad debt expense (see instructions)	see 2,052 2,052 s beyond a lengem? gent care progons) instructions)	2.00 3,445,924 873 3,445,924 0 0 873 3,445,924 9th of stay limit gram's length of	3. 00  12, 085, 488  5, 498, 797  0  5, 498, 797  1. 00  N  0  6, 667, 741  142, 235  218, 823  6, 448, 918	21. 22. 23. 24. 25. 26. 27. 27. 28. 29. 30.

Heal th	Financial Systems	HENDRICKS REGIO	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
					From 01/01/2022 o 12/31/2022	Date/Time Pre	nared.
				'	0 12/31/2022	5/31/2023 12:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +-	
		1.00	2.00	2.00	4.00	col . 4)	
	GENERAL SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	_
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT		25, 702, 069	25, 702, 069	3, 770, 336	29, 472, 405	1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 408, 754	48, 398, 963				
5. 00	00500 ADMINISTRATIVE & GENERAL	15, 846, 016	49, 722, 221	65, 568, 237		62, 040, 730	1
7.00	00700 OPERATION OF PLANT	2, 983, 696	10, 176, 614				1
8.00	00800 LAUNDRY & LINEN SERVICE	404, 899	-299, 504	105, 395	-7, 197	98, 198	8.00
9. 00	00900 HOUSEKEEPI NG	3, 277, 512	1, 035, 831	4, 313, 343			
10.00	01000 DI ETARY	2, 364, 000	1, 948, 844				
11. 00	01100 CAFETERI A	0	0		-,,		
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 374, 539	697, 374				
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY	1, 233, 195	949, 851				
16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	3, 116, 637 450, 344	30, 300, 221 1, 141, 105	33, 416, 858 1, 591, 449			1
17. 00	01700 SOCIAL SERVICE	2, 136, 265	218, 802				1
23. 00	02300 PARAMED ED PRGM-EMS	2, 130, 203	210,002		1	415, 251	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			1107201	110/201	20.00
30.00	03000 ADULTS & PEDIATRICS	20, 603, 977	4, 722, 181	25, 326, 158	-5, 855, 320	19, 470, 838	30.00
31.00	03100 INTENSIVE CARE UNIT	2, 833, 673	1, 883, 319	4, 716, 992	-418, 426	4, 298, 566	31.00
43.00	04300 NURSERY	0	0	C	1, 665, 088	1, 665, 088	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	C	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						4
50.00	05000 OPERATING ROOM	3, 053, 597	15, 463, 948				
50. 01	05001 ENDOSCOPY	1, 371, 914	822, 018			1, 890, 110	
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	1, 945, 714	325, 813 39, 997				
53.00	05300 ANESTHESI OLOGY	7, 336, 482	664, 978				
54. 00	05400 RADI OLOGY-DI AGNOSTI C	7, 295, 054	2, 801, 773				1
54. 01	05401 RADI ATI ON-ONCOLOGY	975, 069	1, 254, 260	2, 229, 329		2, 318, 566	1
56. 00	05600 RADI OI SOTOPE	0	0	_,,		0	1
56. 01	05601 NUCLEAR MEDICINE	364, 866	305, 658	670, 524	-15, 148	655, 376	56. 01
59.00	05900 CARDI AC CATHETERI ZATI ON	742, 544	4, 331, 504	5, 074, 048	-737, 782	4, 336, 266	59.00
60.00	06000 LABORATORY	4, 073, 053	8, 866, 593	12, 939, 646	9, 518	12, 949, 164	60.00
64.00	06400 I NTRAVENOUS THERAPY	1, 823, 109	397, 252				
65.00	06500 RESPI RATORY THERAPY	2, 242, 083	1, 138, 949				
66.00	06600 PHYSI CAL THERAPY	7, 395, 807	678, 327			7, 834, 389	
67.00	06700 OCCUPATI ONAL THERAPY	661, 712	21, 256				1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	375, 884	15, 486				1
69. 00	06901 CARDI AC REHAB	1, 183, 632 853, 255	137, 408 31, 973			1, 453, 508 875, 257	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	759, 173	96, 626				
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	000,777		0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	o	0				
	07300 DRUGS CHARGED TO PATIENTS	O	0		29, 909, 831	29, 909, 831	
	07301 ULTRA SOUND	535, 533	396, 549	932, 082		924, 640	
74.00	07400 RENAL DIALYSIS	0	422, 499			422, 499	
76. 00	03950 WOUND CARE	995, 398	1, 010, 066			2, 006, 276	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS	4 450 (44	0.007.400	F 050 40/	000 004	4 0/7 045	
90.00	09000 CLINIC	1, 453, 644	3, 896, 492			4, 367, 315	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	12, 958, 959	2, 036, 008	14, 994, 967	-1, 107, 160	13, 887, 807	91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
102 00	10200 OPLOLD TREATMENT PROGRAM	0	0	C	0	0	102.00
102.00	SPECIAL PURPOSE COST CENTERS	9			,1		102.00
118.00		121, 429, 989	221, 753, 324	343, 183, 313	1, 101, 675	344, 284, 988	1118.00
	NONREI MBURSABLE COST CENTERS						1
192.00	19200 PHYSICIANS' PRIVATE OFFICES	57, 728, 896	21, 565, 664	79, 294, 560	-1, 103, 973	78, 190, 587	192.00
	19201 HEALTH TRACKS	4, 602, 932	1, 353, 821	5, 956, 753	3, 857	5, 960, 610	192. 01
	07950 PRIMARY CARE CLINIC	699, 881	2, 891, 285			3, 591, 783	1
	07951 PARTNERS IN CARE	0	518				194. 01
	07952 OCCUPATIONAL MEDICINE	826, 588	573, 681	1, 400, 269			1
	07953 FOUNDATION	113, 780	9, 451	123, 231		123, 331	1
	07954 SCHOOL & TOWN CLINICS	1, 687, 174	889, 801	2, 576, 975			1
	07955 MANAGED FACILITY 07956 RENTAL PROPERTIES	444, 329	198, 089 81, 493			642, 810	194.05
	07950 RENTAL PROPERTIES	1, 600, 581	132, 637		1		
200.00		189, 134, 150	249, 449, 764				
		, , , , , , , , , , , ,	, , . 3 .		, 91	.,	

Provi der CCN: 15-0005

Peri od: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/31/2023 12:20 pm

			5/31/2023 12:	
Cost Center Description	Adj ustments	Net Expenses		
	(See A-8)	For		
	/ 00	Allocation		
CENEDAL CEDVICE COCT CENTEDS	6. 00	7.00		
GENERAL SERVICE COST CENTERS  1.00   00100   NEW CAP REL COSTS-BLDG & FLXT	72, 993	29, 545, 398		1.00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT	-255, 989			4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-18, 375, 576		·	5.00
7. 00 00700 OPERATION OF PLANT	-13, 754			7. 00
8.00   00800 LAUNDRY & LINEN SERVICE	-296			8.00
9. 00 00900 HOUSEKEEPI NG	-1, 763			9.00
10. 00   01000   DI ETARY	0	1, 106, 936		10.00
11. 00   01100   CAFETERI A	-1, 104, 608	2, 097, 932		11.00
13.00 O1300 NURSING ADMINISTRATION	-201, 792			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	-909			14.00
15. 00   01500   PHARMACY	0			15.00
16. 00   01600   MEDICAL RECORDS & LIBRARY 17. 00   01700   SOCIAL SERVICE	-926			16. 00 17. 00
17.00   01700   SOCIAL SERVICE 23.00   02300   PARAMED ED PRGM-EMS	-36, 322 -29, 636			23.00
INPATIENT ROUTINE SERVICE COST CENTERS	-29,030	300,010		23.00
30. 00 03000 ADULTS & PEDIATRICS	-5, 407, 950	14, 062, 888		30.00
31. 00 03100   NTENSIVE CARE UNIT	-202, 105			31.00
43. 00   04300   NURSERY	0			43.00
44.00 04400 SKILLED NURSING FACILITY	0			44.00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	-23, 989	12, 552, 131		50.00
50. 01   05001   ENDOSCOPY	0		·	50. 01
51. 00   05100   RECOVERY   ROOM	0			51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0 100 000	3, 377, 355		52.00
53. 00 05300 ANESTHESI OLOGY	-8, 182, 906		1	53.00
54. 00   05400  RADI OLOGY-DI AGNOSTI C 54. 01   05401  RADI ATI ON-ONCOLOGY	-123, 173 0		1	54. 00 54. 01
56. 00   05600   RADI OI SOTOPE	0			56.00
56. 01   05601 NUCLEAR MEDICINE	0	l e	1	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	-1, 847, 365			59.00
60. 00   06000   LABORATORY	-86, 432		l e e e e e e e e e e e e e e e e e e e	60.00
64.00 06400 INTRAVENOUS THERAPY	-463			64.00
65. 00 06500 RESPIRATORY THERAPY	-1, 555	3, 206, 392		65.00
66. 00 06600 PHYSI CAL THERAPY	-1, 036, 127	6, 798, 262		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0			67.00
68. 00 06800 SPEECH PATHOLOGY	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	-187, 137			69.00
69. 01   06901   CARDI AC   REHAB	-328			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			70.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00   07200   MPL. DEV. CHARGED TO PATIENT	0 0		I and the second	71.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT 73. 00   07300   DRUGS CHARGED TO PATIENTS				72. 00 73. 00
73. 00 07300 DR003 CHARGED TO FATTENTS  73. 01 07301 ULTRA SOUND				73.00
74. 00 07400 RENAL DI ALYSI S	0		·	74.00
76. 00 03950 WOUND CARE	-304			76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0		l e e e e e e e e e e e e e e e e e e e	77.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0	4, 367, 315		90.00
91. 00   09100   EMERGENCY	-6, 874, 662	7, 013, 145		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS	T	1	·	
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	<u> </u>	102.00
SPECIAL PURPOSE COST CENTERS  118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-43, 923, 074	300, 361, 914		118. 00
NONREI MBURSABLE COST CENTERS				
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0			192.00
192. 01 19201 HEALTH TRACKS	0			192.01
194. 00 07950 PRIMARY CARE CLINIC	0			194.00
194. 01 07951  PARTNERS IN CARE 194. 02 07952  OCCUPATIONAL MEDICINE	0	518 1, 400, 998		194. 01 194. 02
194. 02 07952 0CCUPATIONAL MEDICINE 194. 03 07953  FOUNDATION	0			194. 02
194. 04 07954 SCHOOL & TOWN CLINICS				194.03
194. 05 07955 MANAGED FACILITY				194.05
194. 06 07956 RENTAL PROPERTIES	0			194.06
194. 07 07957 SNF NON CERTIFIED	0			194. 07
200.00 TOTAL (SUM OF LINES 118 through 199)	-43, 923, 074			200.00

Heal th	Financial Systems		HENDRI CKS REGI	ONAL HEALTH		In Lieu o	of Form CMS-2552-10
	SI FI CATI ONS			Provi der CCI	N: 15-0005	Peri od: W	orksheet A-6
						From 01/01/2022 To 12/31/2022 D	ate/Time Prepared:
						5	/31/2023 12: 20 pm
		Increases					
	Cost Center	Li ne #	Sal ary	Other 5 00			
	2.00 A - DRUGS RECLASS	3. 00	4. 00	5. 00			
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	29, 909, 831			1.00
2. 00	BROOS CHARGED TO TATTENTS	0.00	o	0			2.00
4. 00		0.00	o	Ö			4.00
5. 00		0.00	o	0			5. 00
6.00		0. 00	O	0			6.00
7.00		0. 00	0	0			7. 00
9.00		0. 00	0	0			9. 00
10.00		0. 00	0	0			10.00
11. 00		0. 00	0	0			11.00
12.00		0.00	0	0			12.00
13.00		0.00	0	0			13.00
15. 00 16. 00		0.00	0	0			15.00
17. 00		0. 00 0. 00	0	0			16. 00 17. 00
18. 00		0.00	0	0			18.00
19. 00		0.00	o	o			19. 00
20. 00		0.00	o	Ö			20.00
21. 00		0.00	Ö	Ö			21.00
22.00		0. 00	0	0			22. 00
23.00		0. 00	0	0			23.00
25.00		0. 00	O	0			25.00
26.00		0. 00	0	0			26.00
27.00		0. 00	0	0			27. 00
28. 00		0. 00	0	0			28. 00
29. 00		0. 00	0	0			29. 00
30. 00		0.00	•	0			30.00
	TOTALS		0	29, 909, 831			
1. 00	B - MOB RECLASS EMPLOYEE BENEFITS DEPARTMENT	4.00		65, 963			1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00		76, 836			2.00
3. 00	OPERATION OF PLANT	7. 00		86, 507			3.00
4. 00	LAUNDRY & LINEN SERVICE	8. 00		54, 963			4.00
5. 00	MEDICAL RECORDS & LIBRARY	16. 00		13, 123			5. 00
6. 00	SOCI AL SERVI CE	17. 00		9, 518			6. 00
7.00	PARAMED ED PRGM-EMS	23. 00		5, 348			7.00
8.00	ADULTS & PEDIATRICS	30. 00		32, 762			8.00
9.00	RADI OLOGY-DI AGNOSTI C	54.00		95, 329			9. 00
10.00	RADI ATI ON-ONCOLOGY	54. 01		136, 187			10.00
11. 00	LABORATORY	60. 00		6, 214			11.00
12.00	I NTRAVENOUS THERAPY	64. 00		38, 368			12.00
13.00	PHYSI CAL THERAPY	66.00		82, 021			13.00
14.00	OCCUPATIONAL THERAPY	67.00		37, 853			14.00
15.00	ULTRA SOUND	73. 01		19, 347 207, 736			15.00
16. 00	TOTALS — — — — —	9000		968, 075			16.00
	C - CAFETERIA RECLASS		<u> </u>	700, 075			
1. 00	C - CAPETERIA RECLASS	11. 00	1, 754, 561	1, 446, 432			1.00
50	TOTALS		1, 754, 561	1, 446, 432			1.50
	D - IMPLANTABLE DEVICE RECLAS	SS	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , , , , , , ,			
1.00	IMPL. DEV. CHARGED TO	72. 00	0	12, 809, 054			1.00
	PATI ENT						
2.00		0.00	•	0			2. 00
	TOTALS		0	12, 809, 054			
1 00	E - BONUS/PTO RECLASS	F 00	14 100				4 00
1.00	ADMINISTRATIVE & GENERAL	5. 00	14, 138	0			1.00
2. 00 3. 00	OPERATION OF PLANT	7. 00 8. 00	2, 630 357	0			2. 00 3. 00
4. 00	LAUNDRY & LINEN SERVICE HOUSEKEEPING	9. 00	2, 889	0			4.00
5. 00	DI ETARY	10.00	537	0			5. 00
6. 00	CAFETERI A	11. 00	1, 547	0			6.00
7. 00	NURSING ADMINISTRATION	13. 00	3, 856	o			7.00
8. 00	CENTRAL SERVICES & SUPPLY	14. 00	1, 087	0			8.00
9. 00	PHARMACY	15. 00	2, 747	ő			9.00
10.00	MEDICAL RECORDS & LIBRARY	16. 00	397	Ö			10.00
11. 00	SOCI AL SERVI CE	17. 00	1, 883	0			11.00
12.00	PARAMED ED PRGM-EMS	23. 00	141	0			12.00
13.00	ADULTS & PEDIATRICS	30. 00	14, 094	0			13.00
14.00	INTENSIVE CARE UNIT	31. 00	2, 498	0			14.00
15. 00	NURSERY	43. 00	1, 409	0			15. 00
16. 00	OPERATING ROOM	50. 00	2, 692	0			16.00
17. 00	ENDOSCOPY	50. 01	1, 209	0			17. 00
18.00	RECOVERY ROOM	51.00	1, 715	0			18.00
19. 00	DELIVERY ROOM & LABOR ROOM	52. 00	2, 658	0			19. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/31/2023 12:20 pm | Provider CCN: 15-0005

					5/31/2023 12:	20 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3.00	4. 00	5. 00		
20.00	ANESTHESI OLOGY	53.00	6, 467	0		20.00
21. 00	RADI OLOGY-DI AGNOSTI C	54.00	6, 430	0		21.00
22. 00	RADI ATI ON-ONCOLOGY	54. 01	859	0		22.00
23. 00	NUCLEAR MEDICINE	56. 01	322	0		23. 00
24. 00	CARDI AC CATHETERI ZATI ON	59.00	655	0		24.00
25. 00	LABORATORY	60.00	3, 590	0		25. 00
26. 00 27. 00	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	64. 00 65. 00	1, 607 1, 976	0		26. 00 27. 00
28. 00	PHYSICAL THERAPY	66.00	6, 519	0		28.00
29. 00	OCCUPATIONAL THERAPY	67. 00	583	0		29. 00
30.00	SPEECH PATHOLOGY	68. 00	331	0		30. 00
31.00	ELECTROCARDI OLOGY	69. 00	1, 043	0		31. 00
32. 00	CARDI AC REHAB	69. 01	752	Ö		32. 00
33. 00	ELECTROENCEPHALOGRAPHY	70. 00	669	0		33. 00
34. 00	ULTRA SOUND	73. 01	472	0		34. 00
35. 00	CLINIC	90. 00	1, 281	0		35. 00
36.00	EMERGENCY	91.00	11, 282	0		36. 00
37.00	PHYSICIANS' PRIVATE OFFICES	192. 00	50, 721	0		37.00
38.00	HEALTH TRACKS	192. 01	4, 057	0		38.00
39.00	PRIMARY CARE CLINIC	194. 00	617	0		39.00
40.00	OCCUPATIONAL MEDICINE	194. 02	729	0		40.00
41.00	FOUNDATI ON	194. 03	100	0		41.00
42.00	SCHOOL & TOWN CLINICS	194. 04	1, 482	0		42.00
43.00	MANAGED FACILITY	194. 05	392	0		43.00
44.00	SNF NON CERTIFIED	194. 07	1, 411	0		44.00
45.00	WOUND CARE	<u>76.</u> 00	877	0		45.00
	TOTALS		163, 708	0		
	F - MEDICAL SUPPLY RECLASS					
1. 00	OPERATING ROOM	50. 00		5, 764, 203		1. 00
2.00	ELECTROCARDI OLOGY	69. 00		139, 324		2. 00
3. 00		0. 00	0	0		3. 00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6. 00		0.00	0	0		6.00
7. 00		0.00	0	0		7.00
8. 00		0.00	0	0		8.00
9.00		0. 00 0. 00	0			9.00
10.00			0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13. 00 14. 00		0. 00 0. 00	0	0		13. 00 14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	o	0		16. 00
17. 00		0.00	o	0		17. 00
18. 00		0.00	o	0		18. 00
19. 00		0.00	o	0		19. 00
20. 00		0.00	o	0		20. 00
21. 00		0. 00	ő	Ö		21. 00
23. 00		0.00	Ö	Ö		23. 00
24. 00		0.00	Ö	0		24. 00
25. 00		0.00	o	0		25. 00
26. 00		0.00	o	0		26. 00
27.00		0.00	O	0		27. 00
29.00		0.00	o	0		29.00
30.00		0. 00	o	0		30.00
31.00		0. 00	o	0		31.00
33.00		0. 00	o	0		33.00
34.00		0.00	o	0		34.00
	TOTALS		0	5, 903, 527		
	H - CHILDBIRTH CENTER RECLASS					
1. 00	NURSERY	43. 00	1, 598, 298	65, 381		1.00
2.00	DELIVERY ROOM & LABOR ROOM	5200	<u>3, 213, 1</u> 89	13 <u>1, 4</u> 40		2.00
	TOTALS		4, 811, 487	196, 821		
	I - MEDICAL DIRECTOR RECLASS					
1. 00	ADMINISTRATIVE & GENERAL	5. 00	193, 109	0		1.00
2.00		0. 00	0	0		2.00
3.00		0.00		0		3.00
	TOTALS		193, 109	0		
	J - INTEREST EXPENSE RECLASS					
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	3, 770, 336		1. 00
2.00	FIXT	0.00				2.00
2.00		0. 00 0. 00	0	0		2.00
3. 00	<u> </u>	0.00	0	0		3. 00

Health Financial Systems			HENDRICKS REGIONAL HEALTH			In Lieu of Form CMS-2552		
RECLAS	SI FI CATI ONS			Provi der	CCN: 15-0005	Peri od:	Worksheet A-	6
						From 01/01/2022 To 12/31/2022	Date/Time Pr 5/31/2023 12	epared: : 20 pm
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3.00	4. 00	5. 00				
4.00		0.00	0	0	)			4. 00
	TOTALS		0	3, 770, 336				
	K - EMS EDUCATION RECLASS							
1.00	PARAMED ED PRGM-EMS	23. 00	159, 497	99, 731				1.00
	TOTALS — — — — —		159, 497	99, 731				
	L - EMS CLINICAL PRECEPTOR R	ECLASS						
1.00	PARAMED ED PRGM-EMS	23. 00	150, 534	C	)			1.00
	TOTALS — — — — —		150, 534					1
500.00	Grand Total: Increases		7, 232, 896	55, 103, 807	1			500.00
	•							•

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0005

						5/31/2023 Date/11/lie Pi	
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10. 00		
1. 00	A - DRUGS RECLASS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	102, 611	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	14, 563	-		2.00
4. 00	HOUSEKEEPI NG	9. 00	0	31	0		4. 00
5. 00	NURSI NG ADMI NI STRATI ON	13. 00	0	46	-		5.00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	1, 911	0		6.00
7. 00	PHARMACY	15. 00	0	29, 330, 226	-		7. 00
9. 00	ADULTS & PEDIATRICS	30.00	Ö	6, 756			9. 00
10.00	INTENSIVE CARE UNIT	31. 00	0	1, 072			10.00
11. 00	OPERATING ROOM	50. 00	0	45, 212			11.00
12. 00	ENDOSCOPY	50. 01	0	7, 862			12.00
13. 00	RECOVERY ROOM	51. 00	0	13, 740			13.00
15. 00	ANESTHESI OLOGY	53.00	0	153			15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	o	248, 450			16.00
17.00	RADI ATI ON-ONCOLOGY	54. 01	0	1, 050	0		17.00
18.00	NUCLEAR MEDICINE	56. 01	0	25	0		18. 00
19.00	CARDIAC CATHETERIZATION	59. 00	0	14, 707	0		19.00
20.00	LABORATORY	60.00	0	286	0		20.00
21.00	INTRAVENOUS THERAPY	64. 00	0	8, 780	0		21.00
22.00	RESPI RATORY THERAPY	65. 00	0	10, 291	0		22. 00
23.00	PHYSI CAL THERAPY	66. 00	0	74, 591	0		23. 00
25.00	ELECTROCARDI OLOGY	69. 00	0	7, 899	0		25. 00
26.00	CARDI AC REHAB	69. 01	0	18			26.00
27.00	ELECTROENCEPHALOGRAPHY	70. 00	0	491	0		27. 00
28.00	WOUND CARE	76. 00	0	65	0		28. 00
29.00	CLINIC	90. 00	0	14, 997	0		29. 00
30.00	EMERGENCY	91. 00	0	3, 998			30.00
	TOTALS			29, 909, 831			
	B - MOB RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	968, 075	0		1.00
2.00		0. 00	0	0	0		2.00
3.00		0. 00	0	0	0		3. 00
4. 00		0. 00	0	0	0		4. 00
5. 00		0. 00	0	0	0		5. 00
6. 00		0. 00	0	0	-		6.00
7. 00		0. 00	0	0	0		7. 00
8. 00		0. 00	0	0	0		8. 00
9. 00		0. 00	0	0			9. 00
10.00		0. 00	0	0	-		10.00
11. 00		0. 00	0	0	0		11.00
12.00		0. 00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16. 00	TOTAL C — — — —	0.00	9		0		16. 00
	TOTALS		0	968, 075			
1 00	C - CAFETERIA RECLASS	10.00	1, 754, 561	1 447 422	0		1 00
1. 00	DI ETARY						1.00
	TOTALS  D - IMPLANTABLE DEVICE RECLAS	.c	1, 754, 561	1, 446, 432			
1. 00	OPERATING ROOM	50.00	0	11, 657, 011	0		1.00
2. 00	CLINIC	90.00	0	1, 152, 043	-		2.00
2.00	TOTALS		_	12, 809, 054			2.00
	E - BONUS/PTO RECLASS			12,007,004			
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	163, 708	0	0		1.00
2. 00		0.00	103, 700	0			2.00
3. 00		0.00	0	0			3. 00
4. 00		0. 00	O	0	-		4. 00
5. 00		0.00	0	0			5. 00
6. 00		0.00	0	0	0		6. 00
7. 00		0.00	0	0	0		7. 00
8. 00		0.00	0	0	0		8. 00
9. 00		0.00	0	0	O		9. 00
10.00		0.00	0	0			10.00
11. 00		0. 00	0	0	-		11. 00
12. 00		0. 00	0	0			12.00
13. 00		0. 00	0	0	0		13. 00
14. 00		0.00	0	0	o		14.00
15. 00		0. 00	o o	0	o		15. 00
16. 00		0. 00	0	0	l ol		16. 00
17. 00		0.00	0	0	o		17. 00
18. 00		0.00	0	0	0		18. 00
19. 00		0. 00	0	0	-		19. 00
20. 00		0. 00	0	0			20.00
-		·			. '		

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/31/2023 12: 20 pm

		D				5/31/2023 12	. 20 piii
	01.01	Decreases	6.1	011	WI . I A 7 D C		
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
21 00	6. 00	7. 00	8. 00	9. 00	10.00		21.00
21. 00		0.00	U	0	0		21.00
22. 00		0.00	0	0			22.00
23. 00		0.00	0	0	0		23. 00
24. 00		0.00	0	0	0		24.00
25. 00		0. 00	0	0	0		25. 00
26. 00		0.00	0	0			26. 00
27. 00		0. 00	0	0	0		27. 00
28. 00		0. 00	0	0	0		28. 00
29. 00		0. 00	0	0	0		29. 00
30.00		0. 00	0	0	0		30.00
31. 00		0. 00	0	0	0		31.00
32. 00		0. 00	0	0	0		32. 00
33. 00		0. 00	0	0			33.00
34. 00		0. 00	0	0	0		34.00
35. 00		0. 00	0	0			35. 00
36. 00		0. 00	0	0	0		36. 00
37. 00		0. 00	0	0	0		37.00
38. 00		0. 00	0	0	0		38. 00
39. 00		0. 00	0	0	0		39. 00
40. 00		0. 00	0	0	0		40. 00
41. 00		0. 00	0	0	0		41.00
42. 00		0. 00	0	0	0		42. 00
43.00		0. 00	0	0	0		43.00
44. 00		0. 00	0	0	0		44.00
45. 00	TOTAL C — — — — —	0.00	$  \frac{0}{1}$	0	0		45. 00
	TOTALS		163, 708	0			
1. 00	F - MEDICAL SUPPLY RECLASS EMPLOYEE BENEFITS DEPARTMENT	4. 00		27, 281	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00		41, 070	0		2.00
3. 00	OPERATION OF PLANT	7. 00		20, 940	0		3. 00
4. 00	LAUNDRY & LINEN SERVICE	8. 00		62, 517	0		4. 00
5. 00	HOUSEKEEPI NG	9. 00		95, 581	0		5. 00
6. 00	DI ETARY	10. 00		5, 452	0		6. 00
7. 00	NURSING ADMINISTRATION	13. 00		124, 076	0		7. 00
8. 00	CENTRAL SERVICES & SUPPLY	14. 00		308, 992	0		8.00
9.00	PHARMACY	15. 00		172, 240	0		9. 00
10.00	MEDICAL RECORDS & LIBRARY	16. 00		2, 118	0		10.00
11.00	SOCIAL SERVICE	17. 00		1, 222	0		11.00
12.00	ADULTS & PEDIATRICS	30. 00		887, 112	0		12.00
13.00	INTENSIVE CARE UNIT	31. 00		419, 852	0		13.00
14.00	ENDOSCOPY	50. 01		291, 159	0		14. 00
15. 00	RECOVERY ROOM	51. 00		242, 698	0		15. 00
16. 00	DELIVERY ROOM & LABOR ROOM	52. 00		9, 929	0		16. 00
17. 00	ANESTHESI OLOGY	53. 00		189, 260	0		17. 00
18. 00	RADI OLOGY-DI AGNOSTI C	54. 00		759, 756	0		18. 00
19. 00	RADI ATI ON-ONCOLOGY	54. 01		46, 759	0		19. 00
20. 00	NUCLEAR MEDICINE	56. 01		15, 445	0		20.00
21. 00	CARDIAC CATHETERIZATION	59. 00		723, 730	0		21.00
	INTRAVENOUS THERAPY	64. 00		196, 994	0		23. 00
24. 00	RESPI RATORY THERAPY	65. 00		164, 770	0		24. 00
25. 00	PHYSI CAL THERAPY	66. 00		253, 694	0		25. 00
26. 00	OCCUPATI ONAL THERAPY	67. 00		7, 596	0		26. 00
27. 00	SPEECH PATHOLOGY	68. 00		5, 467	0		27. 00
29. 00	CARDI AC REHAB	69. 01		10, 705	0		29. 00
30.00	ELECTROENCEPHALOGRAPHY	70. 00		62, 643	0		30.00
31.00	ULTRA SOUND	73. 01		27, 261	0		31.00
33. 00	CLINIC	90.00		22, 526	0		33.00
34.00	EMERGENCY	<u>91.</u> 00		704, 682	0		34.00
	TOTALS H - CHILDBIRTH CENTER RECLASS	2	0	5, 903, 527			-
1. 00	ADULTS & PEDIATRICS	30.00	4, 811, 487	196, 821	0		1.00
2. 00	ADDETS & FEDIATRICS	0.00	4, 011, 407	170, 021	0	1	2.00
2.00	TOTALS — — — —		4, 811, 487	196, 821			2.00
	I - MEDICAL DIRECTOR RECLASS		7, 511, 407	170,021			1
1. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	186, 619	0	0		1.00
2. 00	HEALTH TRACKS	192. 01	200	0			2. 00
3. 00	SCHOOL & TOWN CLINICS	194. 04	6, 290	n	0		3. 00
2.00	TOTALS	— — · <i>/</i> · · · · · · · · · · · · · · · · · · ·	193, 109	— — <u> </u>	<u> </u>		5.55
	J - INTEREST EXPENSE RECLASS		.,,,,,,,,				1
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 755, 957	11		1.00
2. 00	OPERATI NG ROOM	50. 00	ol	6, 097	0		2. 00
3. 00	ENDOSCOPY	50. 01	o	6, 010	0		3. 00
4. 00	CLINIC	90. 00	o	2, 272	0		4. 00
	TOTALS	†	— — — ō	3, 770, 336			
		· '					•

Heal th	Financial Systems	HENDRI CKS REG	SI ONAL HEALTH		In Lie	eu of Form CMS-	2552-10	
RECLASSI FI CATI ONS				Provi der	CCN: 15-0005	Peri od:	Worksheet A-	6
						From 01/01/2022 To 12/31/2022		epared: : 20 pm_
		Decreases						
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref	<u>.                                     </u>		
	6. 00	7.00	8. 00	9. 00	10.00			
	K - EMS EDUCATION RECLASS							
1.00	EMERGENCY	91. 00	159, 497	99, 731		0		1.00
	TOTALS		159, 497	99, 731				
	L - EMS CLINICAL PRECEPTOR RI	ECLASS						
1.00	EMERGENCY	91. 00	150, 534	C	)	0		1.00
	TOTALS		150, 534	C				
500.00	Grand Total: Decreases		7, 232, 896	55, 103, 807	1			500.00

				To	12/31/2022	Date/Time Pre 5/31/2023 12:	
				Acqui si ti ons		373172023 12.	20 piii
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	19, 327, 800	2, 377, 476	0	2, 377, 476	0	1.00
2.00	Land Improvements	10, 161, 634	69, 499	0	69, 499	0	2.00
3.00	Buildings and Fixtures	300, 828, 421	5, 388, 650	0	5, 388, 650	0	3.00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	153, 882, 242	5, 279, 576	0	5, 279, 576	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	484, 200, 097	13, 115, 201	0	13, 115, 201	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	484, 200, 097	13, 115, 201	0	13, 115, 201	0	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	21, 705, 276	0				1.00
2.00	Land Improvements	10, 231, 133	0				2.00
3.00	Buildings and Fixtures	306, 217, 071	0				3.00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	159, 161, 818	0				6.00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	497, 315, 298	0				8.00
9.00	Reconciling Items	0	0			ļ	9. 00
10. 00	Total (line 8 minus line 9)	497, 315, 298	0				10.00

Heal th Finar	cial Systems	HENDRI CKS REGI	NDRICKS REGIONAL HEALTH In Lieu c				2552-10
RECONCI LI AT	ON OF CAPITAL COSTS CENTERS		Provider Co	CN: 15-0005	Peri od: From 01/01/2022 To 12/31/2022		pared:
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	I nsurance (see	Taxes (see instructions)	
					instructions)	Thistructrons)	
		9. 00	10. 00	11. 00	12.00	13. 00	
PART	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00 NEW 0	AP REL COSTS-BLDG & FLXT	25, 702, 069	0		0	0	1.00
3.00 Total	(sum of lines 1-2)	25, 702, 069	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
PART	II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2			
1.00 NEW 0	AP REL COSTS-BLDG & FIXT	0	25, 702, 069				1.00
3. 00 Total	(sum of lines 1-2)	0	25, 702, 069				3.00

Health Financial Systems	HENDRI CKS REGI	HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2				
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
				From 01/01/2022 Fo 12/31/2022		nared:
				12/01/2022	5/31/2023 12: 2	
	COME	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cook Contan Documents on	C A	C: +-1:	C	D-+i - (	1	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
		Leases	(col. 1 -	Tristructions)		
			col . 2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS O	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	497, 315, 298		497, 315, 29	1. 000000	0	1.00
3.00 Total (sum of lines 1-2)	497, 315, 298		497, 315, 29			3.00
	ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
		0.11	Table (conscious)			
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capital-Relat ed Costs	cols. 5 through 7)			
	6, 00	7.00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS O		7.00	0.00	7.00	10.00	
1. 00 NEW CAP REL COSTS-BLDG & FLXT	0	0		25, 775, 444	0	1.00
3.00 Total (sum of lines 1-2)	0	0		25, 775, 444		3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see	9 through 14)	
	11. 00	12. 00	13.00	instructions)	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS O		12.00	13.00	14.00	15.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	3, 769, 954	0		0	29, 545, 398	1. 00
3.00 Total (sum of lines 1-2)	3, 769, 954		1	o o	29, 545, 398	3. 00

					o 12/31/2022	Date/Time Pre	pared:
				Expense Classification on To/From Which the Amount is		5/31/2023 12:	20 pm
				10/11 oill will cil the Allount 13	to be Aujusteu		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4.00	Ref. 5.00	
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	В	-382	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2. 00	2) Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00	Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
8. 00	21) Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -24, 143, 207		0.00	0	
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12.00
13.00	transactions (chapter 10) Laundry and linen service		0	0.4557501.4	0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee	В	-1, 104, 608 0	CAFETERTA	11. 00 0. 00	0	
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 patients		0		0.00	0	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,	В	-29, 636	PARAMED ED PRGM-EMS	23. 00	0	19. 00
20. 00			0		0.00	0	
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
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	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL			FIXT *** Cost Center Deleted ***	2.00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99

				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					•		
		D 1 (0 1					
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest		_			-	
33. 00	1993 CARRYFORWARD	Α	70 007	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 00
33.00	1773 CARRITORWARD	_ ^	70,007	FLXT	1.00	,	33.00
22 01	1004 CARRYEORWARD		2 200		1 00	0	22 01
33. 01	1994 CARRYFORWARD	A	3, 288	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 01
				FLXT			
33. 02	ADMITTING TELEPHONE	A	0		0. 00	0	33. 02
	(EQUI PMENT)						
33. 03	ADMITTING TELEPHONE (SALARY)	Α	0		0.00	0	33. 03
33. 04	MARKETING DEPARTMENT	A	-3, 022, 288	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	PHYSICIAN RECRUITMENT	A	0		0.00	0	33. 05
33. 06	I HA LOBBYI NG EXPENSE	A	_10 322	ADMINISTRATIVE & GENERAL	5. 00	0	1
					1	0	
33. 07	AHA LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	HOSPITAL ASSESSMENT FEE	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 09	HIP ASSESSMENT FEE	A	-6, 414, 853	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 10
	(3)						
33. 11	MISC INCOME	В	-91, 462	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 11
33. 12	MISC INCOME	В	l :	ADMINISTRATIVE & GENERAL	5. 00	0	1
33. 13	MISC INCOME	В		OPERATION OF PLANT	7. 00	0	33. 13
33. 14	MISC INCOME	В				0	
				LAUNDRY & LINEN SERVICE	8. 00	0	33. 14
33. 15	MISC INCOME	В		HOUSEKEEPI NG	9. 00	0	
33. 16	MISC INCOME	В	-117, 151	NURSING ADMINISTRATION	13. 00	0	33. 16
33. 17	MISC INCOME	В	-909	CENTRAL SERVICES & SUPPLY	14. 00	0	33. 17
33. 18	MISC INCOME	В	0		0.00	0	33. 18
33. 19	MISC INCOME	В	-926	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 19
33. 20	MISC INCOME	В	1	SOCIAL SERVICE	17. 00	0	33. 20
33. 21	MISC INCOME	В		ADULTS & PEDIATRICS	30. 00	0	1
33. 22	MISC INCOME	В		INTENSIVE CARE UNIT	31. 00	0	33. 22
		1				0	
33. 23	MISC INCOME	В	-23, 989	OPERATING ROOM	50. 00	0	
33. 24	MISC INCOME	В	0		0. 00	0	
33. 25	MISC INCOME	В	0		0. 00	0	33. 25
33. 26	MISC INCOME	В	0		0.00	0	33. 26
33. 27	MISC INCOME	В	-515	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 27
33. 28	MISC INCOME	В	0		0.00	0	33. 28
	MISC INCOME	В	0		0. 00	0	1
33. 30		В	E 000	CARDI AC CATHETERI ZATI ON		0	
	MISC INCOME				59. 00	0	33. 30
33. 31	MISC INCOME	В		LABORATORY	60.00	0	
	MISC INCOME	В	-463	INTRAVENOUS THERAPY	64. 00	0	
33. 33	MISC INCOME	В	0		0. 00	0	33. 33
33. 34	MISC INCOME	В	-141	PHYSI CAL THERAPY	66. 00	0	33. 34
33. 35	MISC INCOME	В	0		0.00	0	33. 35
	MISC INCOME	В	1		0. 00	0	1
	MISC INCOME	В				0	1
				CARRIAC RELIAR	0.00		
	MISC INCOME	В		CARDI AC REHAB	69. 01	0	
	MISC INCOME	В	-304	WOUND CARE	76. 00	0	
33. 40	MISC INCOME	В	0		0. 00	0	33. 40
33. 41	MISC INCOME	В	-22, 075	EMERGENCY	91.00	0	33. 41
	TOTAL (sum of lines 1 thru 49)		-43, 923, 074				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
	COLUMN O, TITLE ZUU. J	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.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10

Provider CCN: 15-0005

					_		5/31/2023 12:	20 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7.00	
1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	372, 773	11, 654	361, 119	211, 500	2, 048	1.00
2.00	5. 00	ADMINISTRATIVE & GENERAL	289, 617	0	289, 617	211, 500	1, 091	2.00
3.00	13. 00	NURSING ADMINISTRATION	84, 641	84, 641	0	211, 500	0	3.00
4.00	17. 00	SOCIAL SERVICE	2, 966	2, 966	0	211, 500	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	5, 397, 975	5, 397, 975	0	211, 500	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	2, 799	2, 799	0	211, 500	0	6.00
7.00	0.00		0	0	0	246, 400	0	7.00
8.00	53. 00	ANESTHESI OLOGY	8, 182, 906	8, 182, 906	0	239, 400	0	8.00
9.00	54. 00	RADI OLOGY-DI AGNOSTI C	122, 658	122, 658	0	271, 900	0	9. 00
10.00	59. 00	CARDIAC CATHETERIZATION	1, 842, 365	1, 842, 365	0	271, 900	0	10.00
11.00	60.00	LABORATORY	86, 424	86, 424	0	260, 300	0	11.00
12.00	65. 00	RESPI RATORY THERAPY	1, 555	1, 555	0	211, 500	0	12.00
13.00	66. 00	PHYSI CAL THERAPY	1, 035, 986	1, 035, 986	0	211, 500	0	13.00
14.00	69. 00	ELECTROCARDI OLOGY	187, 137	187, 137	0	211, 500	0	14.00
15.00	0.00		0	0	0	211, 500	0	15.00
16.00	0.00		0	0	0	211, 500	0	16.00
17.00	0.00		0	0	0	211, 500	0	17.00
18.00	0.00		0	0	0	211, 500	0	18.00
19.00	91.00	EMERGENCY	6, 852, 587	6, 852, 587	o	211, 500	o	19.00
200.00			24, 462, 389	23, 811, 653	650, 736		3, 139	200.00

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 Provider CCN: 15-0005

							5/31/2023 12: 2	20 pm_
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Li mi t	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14.00	
1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	208, 246	10, 412	0	0	0	1.00
2.00	5. 00	ADMINISTRATIVE & GENERAL	110, 936	5, 547	0	0	0	2.00
3.00	13. 00	NURSING ADMINISTRATION	0	0	0	0	0	3.00
4.00	17. 00	SOCIAL SERVICE	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	53. 00	ANESTHESI OLOGY	0	0	0	0	0	8.00
9. 00	54.00	RADI OLOGY-DI AGNOSTI C	o	0	0	0	0	9.00
10.00	59. 00	CARDIAC CATHETERIZATION	o	0	0	0	0	10.00
11.00	60.00	LABORATORY	o	0	0	0	l o	11.00
12.00	65. 00	RESPI RATORY THERAPY	o	0	0	0	O	12.00
13.00	66.00	PHYSI CAL THERAPY	o	0	0	0	O	13.00
14.00	69. 00	ELECTROCARDI OLOGY	o	0	0	0	0	14.00
15.00	0.00		o	0	0	0	0	15.00
16.00	0.00		o	0	0	0	O	16.00
17.00	0.00		O	0	0	0	O	17.00
18.00	0.00		0	0	0	0	O	18.00
19.00	91.00	EMERGENCY	o	0	0	0	0	19.00
200.00			319, 182	15, 959	0	0	0	200.00
	•	'			•	•	, '	

Heal th Financial SystemsHENDRICKS REGIONAL HEALTHIn Lieu of Form CMS-2552-10PROVIDER BASED PHYSICIAN ADJUSTMENTProvider CCN: 15-0005Period: From 01/01/2022Worksheet A-8-2

Date/Time Prepared: 5/31/2023 12: 20 pm 12/31/2022 Cost Center/Physician Provi der Wkst. A Line # Adjusted RCE RCE Adjustment I denti fi er Component Li mi t Di sal I owance Share of col. 14 15. 00 1.00 2.00 16.00 17. 00 18. 00 1. 00 4. 00 EMPLOYEE BENEFITS DEPARTMENT 208, 246 164, 527 152, 873 1.00 2.00 5. 00 ADMINISTRATIVE & GENERAL 0 110, 936 178, 681 178, 681 2.00 3. 00 13. 00 NURSING ADMINISTRATION 0 0 0 84, 641 3.00 0 4.00 17. 00 SOCIAL SERVICE 0 0 2, 966 4.00 5.00 30. 00 ADULTS & PEDIATRICS 0 5, 397, 975 5.00 0 31.00 INTENSIVE CARE UNIT 0 6.00 0 2, 799 6.00 0.00 7.00 0 0 7.00 53. 00 ANESTHESI OLOGY 0 0 8.00 0 8, 182, 906 8.00 9.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 122, 658 9.00 59. 00 CARDI AC CATHETERI ZATI ON 0 0 10.00 1, 842, 365 10.00 11.00 60. 00 LABORATORY 0 86, 424 11.00 65. 00 RESPIRATORY THERAPY 12.00 0 0 0 0 0 0 1,555 12.00 13.00 66. 00 PHYSI CAL THERAPY 1, 035, 986 13.00 187, 137 14.00 69. 00 ELECTROCARDI OLOGY 0 14.00 0.00 0 15.00 0 15.00 16.00 0.00 0 0 0 0 0 16.00 17.00 0.00 0 0 17.00 18.00 0.00 0 0 0 18.00 19.00 91. 00 EMERGENCY 6, 852, 587 19.00 200.00 319, 182 331, 554 24, 143, 207 200.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0005

					To	12/31/2022	Date/Time Pre 5/31/2023 12:	
				CAPI TAL			3/31/2023 12.	20 piii
				RELATED COSTS				
		Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	EMPLOYEE BENEFITS	Subtotal	ADMI NI STRATI V	
			Allocation	FIXI	DEPARTMENT		E & GENERAL	
			(from Wkst A					
			col. 7)					
	CENED	AL SERVICE COST CENTERS	0	1. 00	4. 00	4A	5. 00	
1. 00		NEW CAP REL COSTS-BLDG & FIXT	29, 545, 398	29, 545, 398				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	51, 324, 091	428, 281	51, 752, 372			4. 00
5.00	1	ADMINISTRATIVE & GENERAL	43, 665, 154	2, 123, 299		50, 257, 762	50, 257, 762	5.00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	13, 214, 753 97, 902	3, 473, 436 326, 192		17, 519, 597 536, 919	2, 556, 582 78, 351	7. 00 8. 00
9. 00		HOUSEKEEPI NG	4, 218, 857	152, 980		5, 285, 117	771, 241	9. 00
10.00		DI ETARY	1, 106, 936	574, 471		1, 851, 227	270, 144	
11.00		CAFETERI A	2, 097, 932	102, 021	488, 909	2, 688, 862	392, 378	11.00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	4, 749, 855 1, 872, 321	296, 940 554, 547		6, 265, 762 2, 770, 498	914, 344 404, 290	13. 00 14. 00
15. 00	01500	PHARMACY	3, 917, 139	234, 459		5, 020, 050	732, 561	15.00
16. 00		MEDICAL RECORDS & LIBRARY	1, 601, 925	264, 019		1, 991, 433	290, 604	16. 00
17. 00 23. 00		SOCIAL SERVICE PARAMED ED PRGM-EMS	2, 328, 924	51, 576		2, 975, 771	434, 245	17.00
23.00		IENT ROUTINE SERVICE COST CENTERS	385, 615	97, 494	86, 353	569, 462	83, 100	23. 00
30. 00	03000	ADULTS & PEDIATRICS	14, 062, 888	2, 767, 144	4, 400, 632	21, 230, 664	3, 098, 127	30. 00
31.00		INTENSIVE CARE UNIT	4, 096, 461	302, 153		5, 188, 218		31.00
43. 00 44. 00		NURSERY SKILLED NURSING FACILITY	1, 665, 088 0	57, 200 0		2, 167, 654 0	316, 319 0	43. 00 44. 00
44.00		LARY SERVICE COST CENTERS		0	<u> </u>	<u> </u>	0	44.00
50.00	05000	OPERATING ROOM	12, 552, 131	770, 248		14, 173, 265	2, 068, 262	50.00
50. 01		ENDOSCOPY	1, 890, 110	764, 521	382, 284	3, 036, 915	443, 168	50. 01
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	2, 016, 804 3, 377, 355	939, 996 376, 636		3, 498, 974 4, 649, 299	510, 595 678, 458	51. 00 52. 00
53. 00		ANESTHESI OLOGY	-364, 392	0 0		1, 679, 922	245, 146	
54.00		RADI OLOGY-DI AGNOSTI C	9, 067, 207	1, 176, 753		12, 276, 730	1, 791, 506	54.00
54. 01 56. 00		RADI ATI ON-ONCOLOGY RADI OI SOTOPE	2, 318, 566	471, 181 0	271, 703 0	3, 061, 450	446, 748 0	54. 01 56. 00
56. 00		NUCLEAR MEDICINE	655, 376	18, 072		775, 118	113, 111	56. 00
59. 00		CARDI AC CATHETERI ZATI ON	2, 488, 901	326, 912		3, 022, 723	441, 097	59. 00
60.00		LABORATORY	12, 862, 732	490, 385		14, 488, 075	2, 114, 201	60.00
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	2, 054, 099 3, 206, 392	227, 703 259, 081	508, 010 624, 757	2, 789, 812 4, 090, 230	407, 109 596, 875	64. 00 65. 00
66. 00	1	PHYSI CAL THERAPY	6, 798, 262	675, 840		9, 534, 947	1, 391, 406	66.00
67. 00		OCCUPATI ONAL THERAPY	713, 808	336, 548		1, 234, 742	180, 182	67.00
68. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	386, 234	81, 445		572, 419	83, 531	68.00
69. 00 69. 01		CARDI AC REHAB	1, 266, 371 874, 929	143, 549 168, 034		1, 739, 739 1, 280, 723	253, 875 186, 892	69. 00 69. 01
70. 00		ELECTROENCEPHALOGRAPHY	793, 334	225, 852		1, 230, 730	179, 597	70.00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	12, 809, 054 29, 909, 831	0	0	12, 809, 054		
73. 00		ULTRA SOUND	924, 640	131, 204	149, 226	29, 909, 831 1, 205, 070	4, 364, 652 175, 852	
74.00	07400	RENAL DIALYSIS	422, 499	0	0	422, 499	61, 654	74.00
76.00		WOUND CARE	2, 005, 972	0		2, 283, 340	333, 201	76.00
77. 00		ALLOGENEIC STEM CELL ACQUISITION TIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
90.00		CLINIC	4, 367, 315	700, 222	405, 058	5, 472, 595	798, 599	90.00
91.00	1	EMERGENCY	7, 013, 145	1, 121, 679	3, 524, 666	11, 659, 490	1, 701, 434	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS				0		92. 00
102.00		OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
		AL PURPOSE COST CENTERS	,					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	300, 361, 914	21, 212, 073	32, 940, 471	273, 216, 688	32, 535, 725	118. 00
192 00		IMBURSABLE COST CENTERS PHYSICIANS' PRIVATE OFFICES	78, 190, 587	7, 021, 836	16, 034, 097	101, 246, 520	14, 774, 657	192 00
		HEALTH TRACKS	5, 960, 610	618, 640		7, 861, 803		
		PRIMARY CARE CLINIC	3, 591, 783	0		3, 786, 805	552, 597	
		PARTNERS IN CARE OCCUPATIONAL MEDICINE	518 1, 400, 998	0 149, 139		518 1, 780, 466	76 259, 818	194. 01
		FOUNDATION	1, 400, 998	26, 577		1, 780, 466	26, 502	
194.04	07954	SCHOOL & TOWN CLINICS	2, 572, 167	0	468, 379	3, 040, 546	443, 698	194. 04
		MANAGED FACILITY	642, 810	0	123, 813	766, 623	111, 871	
		RENTAL PROPERTIES SNF NON CERTIFIED	81, 493 1, 734, 629	63, 784 453, 349		145, 277 2, 633, 981	21, 200 384, 369	
200.00		Cross Foot Adjustments	1, 754, 027	455, 547	440,003	2, 033, 701		200.00
201.00		Negative Cost Centers		0	-	0		201. 00
202.00	)	TOTAL (sum lines 118 through 201)	394, 660, 840	29, 545, 398	51, 752, 372	394, 660, 840	50, 257, 762	202. 00

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/31/2023 12:20 pm

					) 12/31/2022	5/31/2023 12:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
			LINEN SERVICE				
		7. 00	8. 00	9. 00	10. 00	11. 00	
	GENERAL SERVICE COST CENTERS	1		1			
	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4	00500 ADMINI STRATI VE & GENERAL	00 07/ 470					5.00
4	00700 OPERATION OF PLANT	20, 076, 179	/15 070				7.00
	00800 LAUNDRY & LINEN SERVICE	0	615, 270	1			8.00
4	00900 HOUSEKEEPI NG 01000 DI ETARY	259, 396	0		2 171 272		9.00
4	01100 CAFETERI A	1, 017, 660 180, 727	0	32, 242	3, 171, 273 0		10.00
	01300 NURSI NG ADMI NI STRATI ON	526, 022	0	139, 713 32, 242	0	3, 401, 680 147, 538	11. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY	941, 177	0		0	79, 287	14.00
	01500 PHARMACY	415, 338	690		0	120, 913	15.00
	01600 MEDICAL RECORDS & LIBRARY	329, 743	0,0	21, 474	0	31, 521	16.00
	01700 SOCIAL SERVICE	327, 743	0	3, 582	0	92, 439	17.00
	02300 PARAMED ED PRGM-EMS	121, 376	0	0, 332	0		23.00
E E	INPATIENT ROUTINE SERVICE COST CENTERS	12.7070		<u> </u>	<u> </u>	12/ / 10	20.00
	03000 ADULTS & PEDIATRICS	4, 275, 057	143, 939	1, 071, 137	2, 518, 649	513, 497	30.00
	03100 INTENSIVE CARE UNIT	535, 255	42, 498		347, 885		31.00
	04300 NURSERY	101, 329	14, 342		0		43.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 364, 473	20, 531	261, 514	0	140, 742	50.00
50. 01	05001 ENDOSCOPY	1, 354, 328	30, 633	136, 131	0	56, 091	50. 01
51.00	05100 RECOVERY ROOM	1, 665, 178	43, 188	128, 966	0	76, 248	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	667, 201	25, 810	179, 120	0	129, 075	52.00
	05300 ANESTHESI OLOGY	0	73, 556	7, 165	0	87, 304	53.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 057, 085	4, 941	429, 887	0	302, 798	54.00
4	05401 RADI ATI ON-ONCOLOGY	0	0	111, 054	0	47, 260	54.01
4	05600 RADI OI SOTOPE	0	0	_	0	1	56.00
	05601 NUCLEAR MEDICINE	32, 014	0	10, 747	0	15, 196	56. 01
	05900 CARDI AC CATHETERI ZATI ON	579, 116	0	71, 648	0	32, 622	59.00
	06000 LABORATORY	669, 874	6, 362		0	238, 832	60.00
	06400 I NTRAVENOUS THERAPY	0	49		0	69, 744	•
1	06500 RESPI RATORY THERAPY	385, 996	0	50, 153	0	90, 862	65.00
	06600 PHYSI CAL THERAPY	427, 002	34, 016		0	317, 625	1
4	06700 OCCUPATI ONAL THERAPY	26, 304	0	,	0	,	67.00
4	06800 SPEECH PATHOLOGY	144, 278	0 500	= .,	0	16, 051	68.00
	06900 ELECTROCARDI OLOGY	254, 293	9, 509		0	, 1, 100	69.00
	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	179, 573 400, 090	88 631		0	35, 642 37, 363	69. 01 70. 00
4	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	400, 040	031	50, 153	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATTENTS	0	0		0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
	07301 ULTRA SOUND	41, 431	0	10, 747	0	19, 634	1
	07400 RENAL DI ALYSI S	0	91	14, 330	0	0	74.00
	03950 WOUND CARE	O	0	0	0	41, 700	76.00
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0		77.00
	OUTPATIENT SERVICE COST CENTERS	'					
	09000 CLI NI C	0	25, 275	272, 262	0	0	90.00
91.00	09100 EMERGENCY	1, 252, 392	96, 317		0	312, 694	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	19, 203, 708	572, 466	5, 176, 555	2, 866, 534	3, 340, 625	118. 00
1	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	69, 375	22, 273		0		192. 00
	19201 HEALTH TRACKS	0	4, 375		0		192. 01
	07950 PRIMARY CARE CLINIC	0	3, 184		0		194. 00
	07951 PARTNERS IN CARE	0	0	0	0		194. 01
	07952 OCCUPATIONAL MEDICINE	0	686		0		194. 02
	07953 FOUNDATION	0	0	-,	0		194. 03
	07954 SCHOOL & TOWN CLINICS	0	301	7, 165	0		194.04
	07955 MANAGED FACILITY	0	0	0	0		194.05
	07956 RENTAL PROPERTIES	000.004	11 005	0	004 700		194.06
	07957 SNF NON CERTIFIED	803, 096	11, 985	0	304, 739		
200.00	Cross Foot Adjustments		_		_		200.00
201.00	Negative Cost Centers TOTAL (sum lines 118 through 201)	20, 076, 179	415 270	6 215 754	0 2 171 272		201.00
202. 00	TOTAL (Sum TITIES TTO LITTUUGH 201)	20,070,179	615, 270	6, 315, 754	3, 171, 273	3,401,000	<sub>1</sub> 202.00

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/31/2023 12:20 pm

			10	12/31/2022	5/31/2023 12:	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
	N 12.00	SUPPLY	15.00	LI BRARY	17.00	
GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9.00
10. 00   01000 DI ETARY						10.00
11. 00   01100   CAFETERI A						11.00
13.00 O1300 NURSING ADMINISTRATION	7, 885, 908					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	4, 205, 999				14.00
15. 00 01500 PHARMACY	0	0	6, 311, 046	0 / 10 001		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	2, 643, 301	2 50/ 027	16.00
17. 00   01700   SOCIAL SERVICE	0	0	0	0	3, 506, 037	
23. 00   O2300   PARAMED ED PRGM-EMS   I NPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	U <sub>I</sub>	0	23.00
30. 00 03000 ADULTS & PEDIATRICS	1, 927, 669	o	0	208, 271	1, 814, 914	30.00
31. 00   03100   NTENSI VE CARE UNI T	391, 350	0	0	51, 211	250, 731	31.00
43. 00   04300   NURSERY	256, 797	o	0	46, 661	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	o	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS	,	-1	- "	-		
50. 00 05000 OPERATING ROOM	528, 349	4, 205, 999	0	494, 671	1, 080, 906	50.00
50. 01   05001   ENDOSCOPY	210, 567	0	0	102, 876	0	50. 01
51.00   05100   RECOVERY ROOM	286, 236	0	0	88, 241	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	484, 550	0	0	88, 044	0	52.00
53. 00 05300 ANESTHESI OLOGY	327, 740	0	0	85, 992	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 136, 708	0	0	199, 713	0	54.00
54. 01   05401   RADI ATI ON-ONCOLOGY	0	0	0	0	0	54.01
56. 00   05600  RADI OI SOTOPE 56. 01   05601  NUCLEAR MEDI CI NE	57, 046	0	0	0	0	56. 00 56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	122, 464	0	0	227, 612	0	59.00
60. 00   06000   LABORATORY	122, 404	0	0	412, 825	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	341, 098	o	0	80, 987	0	65.00
66. 00   06600 PHYSI CAL THERAPY	0	0	0	30, 406	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0	11, 753	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	7, 280	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	278, 475	0	0	57, 551	0	69.00
69. 01   06901   CARDI AC REHAB	133, 800	0	0	6, 860	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	( 211 044	0	0	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 73. 01   07301   ULTRA SOUND	0	0	6, 311, 046	0	0	73. 00 73. 01
74. 00 07400 RENAL DIALYSIS		0	0	2, 901	0	74.00
76. 00 03950 WOUND CARE		0	0	33, 900	0	76.00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION		o	0	0	0	
OUTPATIENT SERVICE COST CENTERS	-1	-1	-1	-1	-	
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
91. 00 09100 EMERGENCY	1, 173, 856	0	0	405, 546	359, 486	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	7 (5) 705	4 005 000	( 011 011	0 (40 004	0.50/.007	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 656, 705	4, 205, 999	6, 311, 046	2, 643, 301	3, 506, 037	1118.00
NONREIMBURSABLE COST CENTERS  192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	l ol	٥	0	O	0	192. 00
192. 01 19201 HEALTH TRACKS	0	0	0	0		192.00
194. 00 07950  PRI MARY CARE CLINIC		0	0	0		194.00
194. 01 07951 PARTNERS IN CARE		0	0	o o		194. 01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	o	o	0	0		194. 02
194. 03 07953 FOUNDATI ON	0	0	0	0		194. 03
194.04 07954 SCHOOL & TOWN CLINICS	0	0	0	0	0	194. 04
194.05 07955 MANAGED FACILITY	0	0	0	0	0	194. 05
194. 06 07956 RENTAL PROPERTIES	0	0	0	o		194. 06
194.07 07957 SNF NON CERTIFIED	229, 203	0	0	o	0	194. 07
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00   TOTAL (sum lines 118 through 201)	7, 885, 908	4, 205, 999	6, 311, 046	2, 643, 301	3, 506, 037	202.00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0005 Peri od: Worksheet B From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/31/2023 12:20 pm Cost Center Description PARAMED ED Total Subtotal Intern & PRGM-EMS Resi dents Cost & Post Stepdown Adjustments 23. 00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17.00 23.00 02300 PARAMED ED PRGM-EMS 786, 886 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 36, 801, 924 0 0 36, 801, 924 30.00 31.00 03100 INTENSIVE CARE UNIT 0 8,051,813 8, 051, 813 31.00 04300 NURSERY 0 0 43.00 2, 985, 838 2, 985, 838 43.00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 24, 338, 712 0 24, 338, 712 50.00 05001 ENDOSCOPY 50.01 0 0 0 5, 370, 709 0 5, 370, 709 50.01 6, 297, 626 51 00 05100 RECOVERY ROOM 0 6, 297, 626 51 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 6, 901, 557 6, 901, 557 52.00 53.00 05300 ANESTHESI OLOGY 2, 506, 825 2, 506, 825 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 00000000 17, 199, 368 17, 199, 368 54.00 54 01 05401 RADI ATI ON-ONCOLOGY 54 01 3, 666, 512 3, 666, 512 56.00 05600 RADI OI SOTOPE 56.00 05601 NUCLEAR MEDICINE 1,003,232 1, 003, 232 56.01 56.01 05900 CARDIAC CATHETERIZATION 59.00 4, 497, 282 4, 497, 282 59.00 60.00 06000 LABORATORY 18, 227, 507 0 18, 227, 507 60.00 0 64.00 06400 I NTRAVENOUS THERAPY 3, 316, 867 3, 316, 867 64.00 06500 RESPIRATORY THERAPY 5, 636, 201 65.00 5, 636, 201 65.00 12, 322, 914 66.00 06600 PHYSI CAL THERAPY 00000 12, 322, 914 0 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 1, 534, 882 1, 534, 882 67.00 68.00 06800 SPEECH PATHOLOGY 845, 053 845, 053 68.00 69 00 06900 ELECTROCARDI OLOGY 2, 724, 940 2, 724, 940 69.00 06901 CARDI AC REHAB 1, 909, 555 1, 909, 555 69.01 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 1, 898, 564 1, 898, 564 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 14, 678, 241 72.00 14, 678, 241 72.00 0 07300 DRUGS CHARGED TO PATIENTS 40, 585, 529 73.00 40, 585, 529 73.00 0 0 1, 452, 734 73.01 07301 ULTRA SOUND 1, 452, 734 73.01 74.00 07400 RENAL DIALYSIS 501, 475 501, 475 74.00 03950 WOUND CARE 0 0 2, 692, 141 76.00 76.00 2, 692, 141 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 6, 568, 731 0 6, 568, 731 90.00 786, 886 09100 EMERGENCY 18, 328, 448 91.00 0 18, 328, 448 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 786, 886 252, 845, 180 0 252, 845, 180 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 116, 897, 368 116, 897, 368 192.00 0 192.01 19201 HEALTH TRACKS 0 0 9, 171, 052 9, 171, 052 192.01 0 194.00 07950 PRIMARY CARE CLINIC 0 4, 453, 640 4, 453, 640 194.00 194. 01 07951 PARTNERS IN CARE 0 0 594 0 594 194.01 194. 02 07952 OCCUPATIONAL MEDICINE 2, 116, 200 0 2, 116, 200 194. 02 194. 03 07953 FOUNDATI ON 211, 697 211, 697 194.03 0 3, 491, 710 194.04 07954 SCHOOL & TOWN CLINICS 3, 491, 710 194.04 0 194.05 07955 MANAGED FACILITY 878, 494 0 878, 494 194.05 194. 06 07956 RENTAL PROPERTIES 0 166, 477 194 06 166, 477 194. 07 07957 SNF NON CERTIFIED 0 4, 428, 428 0 4, 428, 428 194.07 200.00 Cross Foot Adjustments 0 0 0 200.00 201 00 Negative Cost Centers 0 201 00 202.00 TOTAL (sum lines 118 through 201) 786, 886 394, 660, 840 0 394, 660, 840 202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0005

	CAPI TAL			5/31/2023 12:	<u> </u>
RELA	ATED COSTS W BLDG & FLXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIV E & GENERAL	
0	1.00	2A	4. 00	5. 00	
GENERAL SERVICE COST CENTERS					4.00
1.00   00100   NEW CAP REL COSTS-BLDG & FIXT   4.00   00400   EMPLOYEE BENEFITS DEPARTMENT   0   00500   ADMINISTRATIVE & GENERAL   0   00700   OPERATION OF PLANT   0   00700   00700   OPERATION OF PLANT   0   00700   OPERATION OF	428, 281 2, 123, 299 3, 473, 436	428, 281 2, 123, 299 3, 473, 436	428, 281 36, 987 6, 880	2, 160, 286 109, 900	1. 00 4. 00 5. 00 7. 00
8. 00   00800   LAUNDRY & LINEN SERVICE   0   9. 00   00900   HOUSEKEEPING   0   10. 00   01000   DI ETARY   0	326, 192 152, 980 574, 471	326, 192 152, 980 574, 471	934 7, 558 1, 405	3, 368 33, 154 11, 613	8. 00 9. 00 10. 00
11. 00   01100   CAFETERI A	102, 021 296, 940 554, 547	102, 021 296, 940 554, 547	4, 046 10, 088 2, 844	16, 867 39, 305 17, 379	11. 00 13. 00 14. 00
15. 00	234, 459 264, 019 51, 576	234, 459 264, 019 51, 576	7, 187 1, 039 4, 926	31, 491 12, 492 18, 667	15. 00 16. 00 17. 00
23. 00   02300   PARAMED ED   PRGM-EMS   0	97, 494	97, 494	715	3, 572	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   03000   ADULTS & PEDIATRICS   0   03100   INTENSIVE CARE UNIT   0	2, 767, 144 302, 153	2, 767, 144 302, 153	36, 418 6, 535	133, 180 32, 546	30. 00 31. 00
43. 00	57, 200 0	57, 200 0	3, 686 0	13, 598 0	43. 00 44. 00
ANCILLARY SERVICE COST CENTERS  50. 00   05000   OPERATING ROOM   0	770, 248	770, 248	7, 042	88, 909	50. 00
50. 01   05001   ENDOSCOPY 0	764, 521	764, 521	3, 164	19, 051	50. 01
51. 00   05100   RECOVERY ROOM	939, 996	939, 996 376, 636	4, 487 7, 409	21, 949 29, 165	51. 00 52. 00
53. 00   05300   ANESTHESI OLOGY 0	376, 636 0	370, 030	16, 918	10, 538	
54. 00   05400   RADI OLOGY-DI AGNOSTI C 0	1, 176, 753		16, 823	77, 012	54.00
54. 01   05401   RADI ATI ON-ONCOLOGY	471, 181 0	471, 181 0	2, 249 0	19, 204 0	54. 01 56. 00
56. 01   05601   NUCLEAR   MEDI CI NE   0	18, 072	18, 072	841	4, 862	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON 0	326, 912	326, 912	1, 712	18, 962	59. 00
60. 00   06000   LABORATORY	490, 385	490, 385	9, 393	90, 884	60.00
64. 00   06400   I NTRAVENOUS THERAPY   0   65. 00   06500   RESPI RATORY THERAPY   0	227, 703 259, 081	227, 703 259, 081	4, 204 5, 170	17, 500 25, 658	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY 0	675, 840	675, 840	17, 055	59, 813	
67. 00 06700 OCCUPATI ONAL THERAPY 0	336, 548	336, 548	1, 526	7, 746	67. 00
68. 00   06800   SPEECH PATHOLOGY	81, 445	81, 445	867	3, 591	68.00
69. 00   06900   ELECTROCARDI OLOGY	143, 549 168, 034	143, 549 168, 034	2, 729 1, 968	10, 913 8, 034	69. 00 69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY 0	225, 852	225, 852	1, 751	7, 720	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0	o	0	0	0	71.00
72. 00   07200   MPL. DEV. CHARGED TO PATIENT 0	0	0	0	80, 351	
73.00   07300   DRUGS CHARGED TO PATIENTS   0   73.01   07301   ULTRA SOUND   0	0 131, 204	0 131, 204	0 1, 235	187, 624 7, 559	73. 00 73. 01
74. 00   07400   RENAL DI ALYSI S   0	0	0	0		74.00
76. 00 03950 WOUND CARE 0	o	0	2, 295	14, 323	76. 00
77.00 O7700 ALLOGENEIC STEM CELL ACQUISITION 0 OUTPATIENT SERVICE COST CENTERS	0	0	0	0	77. 00
90. 00 09000 CLINIC 0	700, 222	700, 222	3, 352	34, 330	90.00
91. 00   09100   EMERGENCY   0   09200   OBSERVATI ON   BEDS   (NON-DI STI NCT   PART)   0   0   0   0   0   0   0   0   0	1, 121, 679	1, 121, 679 0	29, 169	73, 140	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS  102. 00 10200 OPI 0I D TREATMENT PROGRAM 0  SPECI AL PURPOSE COST CENTERS	0	0	0	0	102. 00
	21, 212, 073	21, 212, 073	272, 607	1, 398, 620	118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0	7, 021, 836	7, 021, 836	132, 686	634, 967	
192. 01   19201   HEALTH TRACKS	618, 640 0	618, 640 0	10, 614 1, 614	49, 317 23, 755	
194. 01 07951 PARTNERS IN CARE 0	0	0	0		194. 00
194. 02 07952 OCCUPATI ONAL MEDI CI NE 0	149, 139	149, 139	1, 906	11, 169	
194. 03 07953 FOUNDATION 0	26, 577	26, 577	262		194. 03
194.04 07954 SCHOOL & TOWN CLINICS 0 194.05 07955 MANAGED FACILITY 0	0	0	3, 876 1, 025	19, 073 4, 809	194. 04 194. 05
194. 06 07956 RENTAL PROPERTIES 0	63, 784	63, 784	0		194.06
194.07 07957 SNF NON CERTIFIED 0	453, 349	453, 349	3, 691	16, 523	
200.00   Cross Foot Adjustments 201.00   Negative Cost Centers	^	0	0		200. 00 201. 00
	29, 545, 398	29, 545, 398	428, 281	2, 160, 286	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/31/2023 | 12: 20 pm

					5/31/2023 12:	20 pm
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10.00	11. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	3, 590, 216					7.00
8. 00   00800 LAUNDRY & LINEN SERVICE	0,000,000	330, 494				8.00
9. 00   00900   HOUSEKEEPI NG	46, 388		240, 080			9. 00
10. 00   01000 DI ETARY	181, 988		1, 226	770, 703		10.00
11. 00   01100   CAFETERI A	32, 319		5, 311	770, 703	160, 564	11.00
				٥		
	94, 068		.,	U	6, 964	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	168, 310		409	0	3, 742	14.00
15. 00   01500   PHARMACY	74, 275		817	0	5, 707	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	58, 968		0	0	1, 488	16.00
17. 00   01700   SOCI AL   SERVI CE	0			0	4, 363	17. 00
23.00 O2300 PARAMED ED PRGM-EMS	21, 706	0	0	0	611	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00  03000 ADULTS & PEDIATRICS	764, 507	77, 316	40, 716	612, 098	24, 237	30.00
31.00  03100 INTENSIVE CARE UNIT	95, 720	22, 828	14, 571	84, 545	4, 921	31.00
43. 00   04300   NURSERY	18, 121	7, 704	545	0	3, 229	43.00
44.00   04400   SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	244, 008	11, 028	9, 941	0	6, 643	50.00
50. 01   05001 ENDOSCOPY	242, 194			o	2, 648	50. 01
51. 00   05100   RECOVERY   ROOM	297, 783			o	3, 599	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	119, 315			o o	6, 093	52.00
53. 00   05300   ANESTHESI OLOGY	117, 319		272	0	4, 121	53.00
				o o		
54. 00   05400   RADI OLOGY-DI AGNOSTI C	189, 038			0	14, 293	54.00
54. 01   05401 RADI ATI ON-ONCOLOGY	0	1	4, 221	0	2, 231	54. 01
56. 00   05600   RADI OI SOTOPE	0	1	0	0	0	56.00
56. 01 05601 NUCLEAR MEDICINE	5, 725			0	717	56. 01
59. 00   05900   CARDI AC CATHETERI ZATI ON	103, 563		2, 724	0	1, 540	59.00
60. 00   06000   LABORATORY	119, 793	3, 418		0	11, 273	60.00
64.00   06400   I NTRAVENOUS THERAPY	0	26	1, 906	0	3, 292	64.00
65. 00 06500 RESPIRATORY THERAPY	69, 028	0	1, 906	0	4, 289	65.00
66. 00 06600 PHYSI CAL THERAPY	76, 361	18, 272	22, 333	0	14, 992	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	4, 704	0	2, 043	o	1, 329	67.00
68. 00 06800 SPEECH PATHOLOGY	25, 801	0	817	o	758	68.00
69. 00 06900 ELECTROCARDI OLOGY	45, 475	5, 108		0	3, 501	69.00
69. 01   06901 CARDI AC REHAB	32, 113			o	1, 682	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	71, 548			o l	1, 764	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		o o	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	•		0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	73.00
	7, 409		-	٥	927	73.00
				U		
74. 00   07400   RENAL DI ALYSI S	0	1	1	0	0	74.00
76. 00 03950 WOUND CARE	0			0	1, 968	76. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	0	13, 577		0	0	90.00
91. 00  09100 EMERGENCY	223, 965	51, 737	22, 061	0	14, 760	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS	<u>'</u>	<u> </u>		'		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 434, 193	307, 502	196, 776	696, 643	157, 682	118. 00
NONREI MBURSABLE COST CENTERS	0, 10 1, 170	007,002	1,0,,,0	0,0,010	1077002	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	12, 406	11, 964	29, 823	ol	0	192. 00
192. 01 19201 HEALTH TRACKS	12, 400			Ö		192. 01
194. 00 07950  PRI MARY CARE CLINIC	0			0		194. 00
				٥		
194. 01 07951 PARTNERS IN CARE 194. 02 07952 OCCUPATIONAL MEDICINE	0	1		0		194. 01 194. 02
	0			0	-	
194. 03 07953 FOUNDATION	0			0		194. 03
194. 04 07954 SCHOOL & TOWN CLINICS	0			0		194. 04
194. 05 07955 MANAGED FACILITY	0	0	0	0		194. 05
194. 06 07956 RENTAL PROPERTIES	0	0	0	0		194. 06
194. 07 07957 SNF NON CERTIFIED	143, 617	6, 438	0	74, 060		194. 07
200.00 Cross Foot Adjustments					ļ	200.00
201.00 Negative Cost Centers	0	0	0	o		201. 00
202.00 TOTAL (sum lines 118 through 201)	3, 590, 216	330, 494	240, 080	770, 703	160, 564	202.00
	•	•				•

			Id	12/31/2022	Date/lime Pre   5/31/2023 12:	
Cost Center Description	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	20 piii
	N 13. 00	SUPPLY 14. 00	15. 00	16. 00	17. 00	
GENERAL SERVICE COST CENTERS	13.00	14.00	13.00	10.00	17.00	
1. 00						1.00 4.00 5.00
7. 00   00700   OPERATION OF PLANT 8. 00   00800   LAUNDRY & LINEN SERVICE 9. 00   00900   HOUSEKEEPING						7.00 8.00 9.00
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A						10. 00 11. 00
13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY	448, 591	747, 231				13. 00 14. 00
15. 00   01500   PHARMACY	0	747, 231	354, 307			15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	338, 006	70 //0	16.00
17. 00   01700   SOCIAL SERVICE 23. 00   02300   PARAMED ED PRGM-EMS	0	0	0	0	79, 668 0	17. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		-1	-			
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT	109, 656 22, 262	0	0	26, 630 6, 548	41, 240 5, 697	30. 00 31. 00
43. 00   04300 NURSERY	14, 608	0	0	5, 966	0	43.00
44.00 O4400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
50. 00 05000 OPERATING ROOM	30, 055	747, 231	0	63, 275	24, 562	50.00
50. 01   05001   ENDOSCOPY	11, 978	0	0	13, 154	0	50. 01
51. 00   05100   RECOVERY ROOM 52. 00   05200   DELI VERY ROOM & LABOR ROOM	16, 283 27, 564	0	0	11, 283 11, 258	0	51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	18, 644	0	0	10, 995	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   05401   RADI ATI ON-ONCOLOGY	64, 662	0	0	25, 536 0	0	54. 00 54. 01
56. 00   05600   RADI 01 SOTOPE	0	O	0	ō	0	56.00
56. 01   05601   NUCLEAR   MEDI CI NE 59. 00   05900   CARDI AC   CATHETERI ZATI ON	3, 245 6, 966	0	0	0 29, 103	0	56. 01 59. 00
60. 00   06000   LABORATORY	0, 700	0	0	52, 785	0	60.00
64. 00   06400   I NTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY	0 19, 403	0	0	10.355	0	64. 00 65. 00
66. 00   06600   PHYSI CAL THERAPY	19, 403	0	0	10, 355 3, 888	0	66.00
67. 00 06700 OCCUPATIONAL THERAPY	0	0	0	1, 503	0	67.00
68. 00   06800   SPEECH   PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY	15, 841	0	0	931 7, 359	0	68. 00 69. 00
69. 01   06901   CARDI AC   REHAB	7, 611	0	0	877	0	69. 01
70. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	70. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	Ö	0	Ö	0	72. 00
73.00   07300   DRUGS CHARGED TO PATIENTS 73.01   07301   ULTRA SOUND	0	0	354, 307	0	0	73. 00 73. 01
74. 00 07400 RENAL DIALYSIS	0	0	0	371	0	74.00
76.00   03950   WOUND CARE 77.00   07700   ALLOGENEIC STEM CELL ACQUISITION	0	0	0	4, 335	0	76.00 77.00
OUTPATIENT SERVICE COST CENTERS	ı o	U <sub>I</sub>	0	U <sub>I</sub>		77.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0	0	0	0	0	90.00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)	66, 775	0	0	51, 854	8, 169	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS				ام		
102. 00 10200 OPI OLD TREATMENT PROGRAM  SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	435, 553	747, 231	354, 307	338, 006	79, 668	118. 00
NONREIMBURSABLE COST CENTERS  192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	O	0	ol	0	192. 00
192. 01 19201 HEALTH TRACKS	0	o	0	ō	0	192. 01
194. 00 07950  PRIMARY CARE CLINIC 194. 01 07951  PARTNERS IN CARE	0	0	0	0		194. 00 194. 01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	0	o	0	Ö		194. 01
194. 03 07953 FOUNDATION	0	0	0	0		194.03
194.04 07954 SCHOOL & TOWN CLINICS 194.05 07955 MANAGED FACILITY		o	0	0		194. 04 194. 05
194. 06 07956 RENTAL PROPERTIES	0	0	0	O		194.06
194.07 07957 SNF NON CERTIFIED 200.00  Cross Foot Adjustments	13, 038	O	O	O	0	194. 07 200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	448, 591	747, 231	354, 307	338, 006	79, 668	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0005 Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/31/2023 12:20 pm Cost Center Description PARAMED ED Subtotal Intern & Total PRGM-EMS Resi dents Cost & Post Stepdown Adjustments 23. 00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17 00 23.00 02300 PARAMED ED PRGM-EMS 124, 098 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 4, 633, 142 30.00 03000 ADULTS & PEDIATRICS 4, 633, 142 0 0 30.00 31.00 03100 INTENSIVE CARE UNIT 598, 326 598, 326 31.00 04300 NURSERY 0 124, 657 43.00 43.00 124, 657 04400 SKILLED NURSING FACILITY 0 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2,002,942 0 2,002,942 50.00 05001 ENDOSCOPY 0 50.01 1,078,340 1,078,340 50.01 0 1, 323, 480 51.00 05100 RECOVERY ROOM 1, 323, 480 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 598, 113 598, 113 52.00 0 53.00 05300 ANESTHESI OLOGY 100, 999 100, 999 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 1, 583, 112 1, 583, 112 54.00 05401 RADI ATI ON-ONCOLOGY 0 54 01 499, 086 499, 086 54 01 0 05600 RADI OI SOTOPE 56.00 56.00 05601 NUCLEAR MEDICINE 33, 871 0 33, 871 56.01 56.01 05900 CARDIAC CATHETERIZATION 59.00 491, 482 0 491, 482 59.00 06000 LABORATORY 0 789, 234 789, 234 60.00 60 00 06400 I NTRAVENOUS THERAPY 0 64.00 254, 631 254, 631 64.00 06500 RESPIRATORY THERAPY 394, 890 394, 890 65.00 66.00 06600 PHYSI CAL THERAPY 888, 554 0 888, 554 66.00 0 06700 OCCUPATIONAL THERAPY 355, 399 355, 399 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 114, 210 114, 210 68.00 69 00 06900 ELECTROCARDI OLOGY 236, 654 0 236, 654 69.00 06901 CARDI AC REHAB 0 69.01 223, 634 69.01 223, 634 οĺ 07000 ELECTROENCEPHALOGRAPHY 70.00 310,880 310, 880 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 80, 351 0 80, 351 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 541, 931 541, 931 73 00 0 73.01 07301 ULTRA SOUND 148, 743 148, 743 73.01 74.00 07400 RENAL DIALYSIS 3, 615 0 3, 615 74.00 0 03950 WOUND CARE 76.00 22, 921 22, 921 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 761, 830 0 761, 830 90.00 0 09100 EMERGENCY 91.00 1,663,309 1, 663, 309 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 00 00 01 าก

SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	19, 858, 336	0	19, 858, 336	118. 00
NONREI MBURSABLE COST CENTERS					
192.00 19200 PHYSICIANS' PRIVATE OFFICES		7, 843, 682	0	7, 843, 682	192. 00
192. 01 19201 HEALTH TRACKS		686, 913	0	686, 913	192. 01
194.00 07950 PRIMARY CARE CLINIC		31, 300	0	31, 300	194. 00
194. 01 07951 PARTNERS IN CARE		3	0	3	194. 01
194. 02 07952 OCCUPATI ONAL MEDI CI NE		165, 442	0	165, 442	194. 02
194. 03 07953  FOUNDATI ON		28, 114	0	28, 114	194. 03
194.04 07954 SCHOOL & TOWN CLINICS		23, 383	0	23, 383	194. 04
194.05 07955 MANAGED FACILITY		5, 834	0	5, 834	194. 05
194. 06 07956 RENTAL PROPERTIES		64, 695	0	64, 695	194. 06
194.07 07957 SNF NON CERTIFIED		713, 598	0	713, 598	194. 07
200.00 Cross Foot Adjustments	124, 098	124, 098	0	124, 098	200. 00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00   TOTAL (sum lines 118 through 201)	124, 098	29, 545, 398	0	29, 545, 398	202.00

				o 12/31/2022	Date/Time Pre 5/31/2023 12:	
Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	20 piii
		SALARI ES)				
	1. 00	4. 00	5A	5. 00	7. 00	
GENERAL SERVICE COST CENTERS	0/4 5//		1	1		4 00
1.00   00100   NEW CAP REL COSTS-BLDG & FIXT   4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	861, 566 12, 489	185, 889, 104				1. 00 4. 00
5. 00 00500 ADMINI STRATI VE & GENERAL	61, 917	16, 053, 263	•	344, 403, 078		5.00
7. 00 00700 OPERATION OF PLANT	101, 288	2, 986, 326			330, 480	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	9, 512	405, 256	1		0	8. 00
9. 00   00900   HOUSEKEEPI NG	4, 461	3, 280, 401	1	-,,	4, 270	9.00
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A	16, 752 2, 975	609, 976 1, 756, 108		,	16, 752 2, 975	10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	8, 659	4, 378, 395			8, 659	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	16, 171	1, 234, 282			15, 493	14.00
15. 00 01500 PHARMACY	6, 837	3, 119, 384			6, 837	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	7, 699	450, 741		, , , , , , , , , , , , , , , , , , , ,	5, 428	16.00
17.00   01700   SOCIAL SERVICE 23.00   02300   PARAMED ED PRGM-EMS	1, 504 2, 843	2, 138, 148 310, 172		, , , , ,	0 1, 998	17. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	2,043	310, 172	.1	307, 402	1, 770	25.00
30. 00 03000 ADULTS & PEDIATRICS	80, 692	15, 806, 584	. 0	21, 230, 664	70, 373	30. 00
31.00 03100 INTENSIVE CARE UNIT	8, 811	2, 836, 171		.,	8, 811	31.00
43. 00   04300   NURSERY	1, 668	1, 599, 707	1	1 ' '	1, 668	43.00
44.00 O4400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	) <u> </u>	ıl U	0	44.00
50. 00 05000 OPERATING ROOM	22, 461	3, 056, 289	0	14, 173, 265	22, 461	50.00
50. 01   05001   ENDOSCOPY	22, 294	1, 373, 123	c c	3, 036, 915	22, 294	50. 01
51. 00   05100   RECOVERY ROOM	27, 411	1, 947, 429	1		27, 411	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY	10, 983	3, 215, 847	1	., ,	10, 983 0	52. 00 53. 00
54. 00   05300   ANESTHESTOLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	34, 315	7, 342, 949 7, 301, 484	•	, , , ,	17, 401	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	13, 740	975, 928	•		0	54. 01
56. 00   05600   RADI OI SOTOPE	0	0	0	0	0	56.00
56. 01 05601 NUCLEAR MEDICINE	527	365, 188	•		527	56. 01
59. 00   05900   CARDI AC CATHETERI ZATI ON 60. 00   06000   LABORATORY	9, 533 14, 300	743, 199 4, 076, 643	1		9, 533 11, 027	59. 00 60. 00
64. 00   06400   NTRAVENOUS THERAPY	6, 640	1, 824, 716	1		11,027	64.00
65. 00 06500 RESPIRATORY THERAPY	7, 555	2, 244, 059			6, 354	65.00
66. 00 06600 PHYSI CAL THERAPY	19, 708	7, 402, 326			7, 029	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	9, 814	662, 295		.,	433	67.00
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	2, 375 4, 186	376, 215 1, 184, 675			2, 375 4, 186	68. 00 69. 00
69. 01   06901   CARDI AC   REHAB	4, 900	854, 007			2, 956	69.01
70. 00 07000 ELECTROENCEPHALOGRAPHY	6, 586	759, 842			6, 586	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	_	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1	,,	0	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 73. 01   07301   ULTRA SOUND	3, 826	536, 005			0 682	73. 00 73. 01
74. 00   07400   RENAL DI ALYSI S	3, 020	330, 003			002	74.00
76.00 03950 WOUND CARE	0	996, 275	o o	1	0	76.00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC	20, 419	1, 454, 925		5, 472, 595	0	90.00
91. 00   09100   EMERGENCY	32, 709	12, 660, 210	1		20, 616	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	02,707	12,000,210		11,007,170	20,010	92.00
OTHER REIMBURSABLE COST CENTERS						
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS  118.00 SUBTOTALS (SUM OF LINES 1 through 117)	618, 560	118, 318, 543	-50, 257, 762	222, 958, 926	316, 118	110 00
NONREIMBURSABLE COST CENTERS	018, 300	110, 310, 343	-50, 257, 702	222, 430, 420	310, 110	110.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	204, 762	57, 592, 998	0	101, 246, 520	1, 142	192. 00
192. 01 19201 HEALTH TRACKS	18, 040	4, 606, 789		.,,		192. 01
194. 00 07950 PRI MARY CARE CLINIC	0	700, 498		-, ,		194. 00 194. 01
194. 01 07951  PARTNERS IN CARE 194. 02 07952  OCCUPATIONAL MEDICINE	4, 349	827, 317	'l ~	518 1, 780, 466		194.01
194. 03 07953 FOUNDATI ON	775	113, 880		181, 613		194. 03
194.04 07954 SCHOOL & TOWN CLINICS	0	1, 682, 366	0	3, 040, 546		194. 04
194. 05 07955 MANAGED FACILITY	0	444, 721	] 0	766, 623		194. 05
194. 06 07956  RENTAL PROPERTIES 194. 07 07957  SNF NON CERTIFIED	1, 860 13, 220	1, 601, 992		145, 277 2, 633, 981	0 13, 220	194. 06 194. 07
200.00 Cross Foot Adjustments	13, 220	1, 501, 372		2,033,701	13, 220	200.00
201.00 Negative Cost Centers			]			201.00

Health Fina	ancial Systems	HENDRICKS REGIONAL HEALTH			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provider Co		Period: From 01/01/2022 To 12/31/2022		pared:	
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	PLANT		
		1.00	4. 00	5A	5. 00	7. 00		
202. 00	Cost to be allocated (per Wkst. B, Part I)	29, 545, 398	51, 752, 372		50, 257, 762	20, 076, 179	202.00	
203. 00	Unit cost multiplier (Wkst. B, Part I)	34. 292669	0. 278405		0. 145927	60. 748545	203.00	
204. 00	Cost to be allocated (per Wkst. B, Part II)		428, 281		2, 160, 286	3, 590, 216	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part		0. 002304		0. 006273	10. 863641	205. 00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0005

Cost Center Description						T-	rom 01/01/2022 o 12/31/2022		
CPUIDES OF LININGS   SERVICE   DAYS   N   CINETIS   SERVICE   DAYS   CINETIS   SERVICE   COST CENTERS   SERVICE   COST			Cost Center Description	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A		20 pili
Chargery						,	(MANHOURS)		
CREATED SERVICE COST CENTERS   10.00   10.00   11.00   13.00   10.00				7	SERVICE)	DATS)			
CREMINI, SERVICE COST CONTENTS				9.00	0.00	10.00	11 00		
4.00   OBDUCE DEPLOYEE SERVET IS DEPLOYMENT		GENER	AL SERVICE COST CENTERS	8.00	9.00	10.00	11.00	13.00	
5.00   00000   AMININ STRATI VE & GENERAL		1	i i						
7. COLOR DEPTICATION OF PLAYIF STRYLE CENTERS 7975, 30 0 1,760 0 9000 (MINESTEEPI NG 0 1,760 0 1,760 0 1,760 0 1,760 0 1,760 0 1,964,552 1 1,000 1 1,000 1 1,000 0 1,000 (MINESTEEPI NG 0 1,000 0 1,000 0 1,964,552 1 1,000 1 1,000 1 1,000 0 1,000 (MINESTEEPI NG 0 1,000 0 1,000 0 1,964,552 1 1,000 1 1,000 1 1,000 0 1,000 (MINESTEEPI NG 0 1,000 0 1,000 0 1,964,552 1 1,000 1 1,									
9.000 10.00   10.000   10.000   17.65  11.00   10.000   10.000   12.000   12.000   11.00   10.000   12.000   12.000   12.000   11.00   10.000   12.000   12.000   12.000   11.00   10.000   12.000   12.000   12.000   11.00   10.000   12.000   12.000   12.000   11.00   10.000   12.000   12.000   12.000   11.00   10.000   12.000   12.000   12.000   11.00   10.000   12.000   12.000   12.000   12.00   10.000   12.000   12.000   12.000   12.00   10.000   12.000   12.000   12.00   10.000   12.000   12.000   12.00   10.000   12.000   12.000   12.00   10.000   12.000   12.000   12.00   10.000   12.000   12.000   12.00   12.000   12.000   12.000   12.00   12.000   12.000   12.000   12.00   12.000   12.000   12.000   12.00   12.000   12.000   12.000   12.00   12.000   12.000   12.00   12.000   12.000   12.000   12.00   12									
10.00   10000   LETARY   0   9   24,590   1.964,552   1.901   1.00   1.00   1.10   1.00   1.10   1.00   1.10   1.00   1.10   1.00   1		1	l i	975, 362					
11.00   01100   01100   02   0   0   0   0   0   0   0   0		1	l i	0	1, 763				•
14.00   01400  CNITMAL SERVICES & SURPLY   0   3   0   45,790   0   15,00   15,00   1500   10100  MDICAL RECORDS & LIBRARY   0   0   0   0   18,204   0   15,00   15,00   10100  MDICAL RECORDS & LIBRARY   0   0   0   0   18,204   0   10,00   17,00   17,00   17		1	l .	0	39		1, 964, 552		
15.00   01500   PIARMANCY   1,094   6   0   69,830   0   15,004   16,00   17,00   01700   5001   AL SERVICE   0   1   0   0   53,360   0   17,00   1		1	l I	0	9	0			
16.00   01-600   MEDICAL RECORDS & LIBRARY   0   0   0   16,000   23,000		1	l .	0 1 094	3	0		_	
23.00				0	0	_			
IMPAIL ENT ROUTINE SERVICE COST CENTERS   228, 177, 299   19, 497   296, 556   296, 556   31, 00   31, 00   0300   INTENSIVE CARE UNIT   67, 371   107   2, 693   60, 206   60, 206   31, 00   43, 00   4300   MIRSERY   22, 736   4   0   0   0   0   0   0   0   0   44, 00		1	l .	0	1				
30.00   30000   ADULTIS & PEDIATRICS   228, 177   299   19, 497   296, 586   296, 555   30.00   31.00   30310   03100   30300   MIRSES W   227, 736   4	23.00			U	0	0	7, 478	0	23.00
43.00   04300   NURSERY   22,736   4   0   39,506   39,506   43,00	30.00			228, 177	299	19, 497	296, 556	296, 556	30.00
44.00   AMCILLARY SERVICE COST CENTERS		1	l I				·		
AMCILLARY SERVICE COST CENTERS  50. 00   000000   OPERATINA GROWN  50. 01   050001   OPERATINA GROWN  50. 00   050000   OPERATINA GROWN  50. 00   05000   OREGINA GROWN  50. 00   05000   OR					- 1				•
50.01   50.00   ENDOSCOPY   48, 56.2   38   0   32, 394   32, 394   50.01		ANCI L	LARY SERVICE COST CENTERS						
51.00							·		
52.00   05200   DELIVERY ROOM & LABOR ROOM									
54. 00   05400   RADIOLOGY-DI AGNOSTI C   7,833   120   0   174,873   54,00   140,00   140,00   140,00   140,00   150,	52.00	05200	DELIVERY ROOM & LABOR ROOM	40, 915	50	_	74, 544	74, 544	52.00
54. 01   54.01   RADIATION-ONCOLOGY   0   31   0   27, 294   0   54. 01		1	l .						
56.00		1	i i	7, 633					
59.00   05900   CARDIA CATHETER ZATION   0   20   0   18, 840   18, 840   69.00		1	l i	0	0	_	0	_	
60.00   06000   LABORATORY   10.086   83   0   137.931   0   60.00   06.00   06.00   NTRAVENOUS THERAPY   0   14   0   52.475   52.475   65.00   65.00   06500   RESPIRATORY THERAPY   0   14   0   52.475   52.475   65.00   66.00   06600   PRYSI CAL THERAPY   53.924   164   0   183.436   0   67.00   67.00   06700   0CCUPATI ONAL THERAPY   0   15   0   16.266   0   67.00   68.00   06900   PRYSI CAL THERAPY   0   15   0   16.266   0   67.00   68.00   06900   ELECTROCARDIOLOGY   15.074   16   0   42.841   42.841   69.00   69.01   06900   ELECTROCARDIOLOGY   15.074   16   0   42.841   42.841   69.00   69.01   06900   ELECTROCARDIOLOGY   15.074   16   0   42.841   42.841   69.00   69.01   06900   ELECTROCARDIOLOGY   15.074   16   0   0   0   0   0   0   0   0   0		1	l i	0					
65 00   06500   RESPIRATORY THERAPY   0   14   0   52, 475   65 00   66 00   0660   PMYSICAL HERAPY   53, 924   164   0   183, 436   0   66 00   0660   PMYSICAL HERAPY   0   15   0   16, 266   0   67 00   06700   06200				10, 086					•
66.00   06600   PHYSI CAL THERAPY   53,924   164   0   183,436   0   66.00   67.00   06700   OCCUPATIONAL THERAPY   0   15   0   16.266   0   67.00   06800   OCCUPATIONAL THERAPY   0   0   0   0   0   0   0   0   0				78					
67. 00   06700   06700   06700   06700   06700   06700   06800   06700   068		1	l .	53 924					
69, 00   06900   CLECTROCARDIOLOCY   15, 074   16   0   42, 841   42, 841   69, 00		1	l I	0					•
69.01   06901   06901   06901   06901   06901   06901   06901   070000   070000   070000   070000   070000   070000   070000   070000   070000   070000   070000   0700000   0700000   0700000000				0					
10.00   07000   07000   CALPATE									
72. 00   07200   IMPL DEV CHARGED TO PATIENT   0   0   0   0   0   0   72. 00	70.00	07000	ELECTROENCEPHALOGRAPHY						
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   73. 01   07301   LITRA SOUND   0   3   0   111,339   0   73. 00   74. 00   07400   RENAL DI ALYSIS   144   4   0   0   0   0   74. 00   76. 00   07400   RENAL DI ALYSIS   144   4   0   0   0   0   74. 00   77. 00   07700   ALLOGENEIC STEM CELL ACQUISITION   0   0   0   0   0   0   0   00000   07700   ALLOGENEIC STEM CELL ACQUISITION   0   0   0   0   0   0   00000   07700   ALLOGENEIC STEM CELL ACQUISITION   0   0   0   0   0   0   00000   09000   CLINIC   0   0   0   0   0   0   0   09000   09000   085ERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   00000   09200   085ERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   00000   09200   085ERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   00000   09200   085ERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   00000   09200   085ERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0		1	l .	0	0	0	0		
73.0   07301   ULTRA SOUND   0   3   0   11, 339   0   73.01				0	0	0	0		
76. 00 03950 WOUND CARE 0 0 0 0 0 24,083 0 76.00 77.00 O7700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 77.00 O7700 O7700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 77.00 O7700 O7700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73. 01	07301	ULTRA SOUND	0			11, 339		
77. 00   07700   ALLOGENEIC STEM CELL ACQUISITION   0   0   0   0   0   0   0   0   0									
OUTPATI ENT SERVICE COST CENTERS   90.00   09000   CLINIC     40,068   76   0   0   0   0   0   0   0   0   0				-					
91. 00   09100   EMERGENCY   152, 688   162   0   180, 588   180, 588   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   102. 00   00   0   0   0   0   0   0   0		OUTPA	TIENT SERVICE COST CENTERS				_	_	
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   92. 00   0THER REIMBURSABLE COST CENTERS   92. 00   0   0   0   0   0   0   0   0   102. 0									
102.00   102.00   OPI OI D TREATMENT PROGRAM   O O O O O O O O O O O O O O O O O O				132, 000	102		100, 300	100, 300	
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   907,506   1,445   22,190   1,929,291   1,177,920   118.00   NONREI MBURSABLE COST CENTERS   S1,309   219   0   0   0   192.00   192.00   192.01	100.00					^	0		100.00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   907,506   1,445   22,190   1,929,291   1,177,920   118.00	102.00			U	0	0	0	0	102.00
192.00 192.01 19200 PHYSICIANS' PRIVATE OFFICES 35, 309 192.01 194.01 194.00 1950 PRI MARY CARE CLINIC 5, 048 31 0 0 0 194.00 194.00 194.01 194.02 194.02 1950 PARTNERS IN CARE 0 0 0 0 0 0 194.00 194.01 194.02 194.02 1950 POLIPATIONAL MEDICINE 1, 087 21 0 0 0 0 194.01 194.02 194.03 1950 FOUNDATION 0 0 194.03 194.04 19754 SCHOOL & TOWN CLINICS 477 2 0 0 0 0 0 0 0 194.05 194.05 1950 RENTAL PROPERTIES 0 0 0 0 0 0 0 0 0 194.05 194.07 200.00 201.00 Negative Cost Centers 200.00 202.00 Cost to be allocated (per Wkst. B, Part I) Part I)	118.00	)	SUBTOTALS (SUM OF LINES 1 through 117)	907, 506	1, 445	22, 190	1, 929, 291	1, 177, 920	118. 00
192.01 19201 HEALTH TRACKS 6, 935 44 0 0 0 192.01 194.00 194.00 194.01 194.01 194.01 194.01 194.02 194.02 194.02 194.03 194.03 194.03 194.03 194.04 194.05 194.05 194.05 194.05 194.06 194.07 1	102.00			3E 300	210	0	0	0	102 00
194. 00   07950   PRI MARY CARE CLINIC   5,048   31   0   0   0   194. 00   194. 01   07951   PARTNERS IN CARE   0   0   0   0   0   194. 02   07952   OCCUPATI ONAL MEDI CINE   1,087   21   0   0   0   194. 03   07953   FOUNDATI ON   0   1   0   0   194. 04   07954   SCHOOL & TOWN CLINICS   477   2   0   0   0   194. 05   07955   MANAGED FACILITY   0   0   0   194. 06   07956   RENTAL PROPERTIES   0   0   0   194. 07   07957   SNF NON CERTIFIED   19,000   0   2,359   35,261   35,261   200. 00   Cross Foot Adjustments   Negative Cost Centers   Part I)   Part I   0   202. 00   Cost to be allocated (per Wkst. B, Part I)   615,270   6,315,754   3,171,273   3,401,680   7,885,908   202.00									
194. 02 07952	194.00	07950	PRIMARY CARE CLINIC				0		
194. 03 07953 FOUNDATION 0 1 0 0 0 194. 03 194. 04 07954 SCHOOL & TOWN CLINICS 477 2 0 0 0 0 194. 04 194. 05 07955 MANAGED FACILITY 0 0 0 0 0 0 194. 05 194. 06 07956 RENTAL PROPERTIES 0 0 0 0 0 0 194. 06 194. 07 07957 SNF NON CERTIFIED 19, 000 0 2, 359 35, 261 35, 261 194. 07 200. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 615, 270 6, 315, 754 3, 171, 273 3, 401, 680 7, 885, 908 202. 00				0 1 087		0	0		
194. 05 07955 MANAGED FACILITY 0 0 0 0 0 0 194. 05 194. 06 07956 RENTAL PROPERTIES 0 0 0 0 0 0 194. 06 194. 07 07957 SNF NON CERTIFIED 19,000 0 2,359 35, 261 35, 261 194. 07 200. 00 194. 08 201. 00 194. 08 201. 00 194. 08 201. 00 194. 08 201. 00 194. 08 201. 00 194. 08 201. 00 194. 08 201. 00 194. 08 201. 00 194. 08 201. 00 194. 08 201. 00	194. 03	07953	FOUNDATI ON	0	1	ő	0		
194.06 07956 RENTAL PROPERTIES 0 0 0 0 0 0 194.06 194.07 07957 SNF NON CERTIFIED 19,000 0 2,359 35,261 35,261 194.07 200.00 Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 615,270 6,315,754 3,171,273 3,401,680 7,885,908 202.00				477	2		0		
194.07 07957 SNF NON CERTIFIED 19,000 0 2,359 35,261 35,261 194.07 200.00 Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 615,270 6,315,754 3,171,273 3,401,680 7,885,908 202.00				0	-		0		
200.00   Cross Foot Adjustments   200.00   201.00   Negative Cost Centers   Cost to be allocated (per Wkst. B, Part I)   615,270   6,315,754   3,171,273   3,401,680   7,885,908   202.00			SNF NON CERTIFIED	19, 000	-		35, 261		
202.00 Cost to be allocated (per Wkst. B, Part I) 615,270 6,315,754 3,171,273 3,401,680 7,885,908 202.00	200.00		Cross Foot Adjustments						200. 00
Part I)		1		615 270	6 315 754	3 171 272	3 401 690	7 885 908	
203.00   Unit cost multiplier (Wkst. B, Part I)   0.630812   3,582.390244   129.181352   1.731530   6.500191   203.00	202.00		Part I)	515, 270	5, 515, 754	5, 1, 1, 2/3	3, 401, 000	7, 000, 700	_52.00
	203.00	)	Unit cost multiplier (Wkst. B, Part I)	0. 630812	3, 582. 390244	129. 181352	1. 731530	6. 500191	203. 00

Health Financial Systems		HENDRICKS REGIONAL HEALTH			In Lieu of Form CMS-2552-10			
COST ALLO	CATION - STATISTICAL BASIS		Provi der Co	CN: 15-0005	Peri od:	Worksheet B-1		
					From 01/01/2022 To 12/31/2022			
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG		
		LINEN SERVICE	(HOURS OF	(PATI ENT	(MANHOURS)	ADMI NI STRATI O		
		(POUNDS OF	SERVI CE)	DAYS)		N		
		LAUNDRY)				(DI RECT		
		,				NRSING HRS)		
		8. 00	9. 00	10.00	11.00	13.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	330, 494	240, 080	770, 70	160, 564	448, 591	204.00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 338842	136. 176971	31. 39447	0. 081731	0. 369764	205. 00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

	LLOCATION - STATISTICAL BASIS	TIENDRI CRO REGI	Provi der CC		eri od:	Worksheet B-1	
					rom 01/01/2022 o 12/31/2022	Date/Time Pre	pared:
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	5/31/2023 12: PARAMED ED	20 pm
	<u>'</u>	SERVICES &	(100%	RECORDS &	SERVI CE	PRGM-EMS	
		SUPPLY (100%	ALLOCATION)	LI BRARY	(TIME SPENT)	(ASSI GNED TIME)	
		ALLOCATION)		(C)	SPENT)	IIWE)	
		14. 00	15. 00	16. 00	17. 00	23. 00	
1 00	GENERAL SERVICE COST CENTERS	1			1		1 00
1. 00 4. 00	OO100 NEW CAP REL COSTS-BLDG & FIXT OO400 EMPLOYEE BENEFITS DEPARTMENT						1.00
5. 00	00500 ADMINI STRATI VE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11. 00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY	100	100				14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	100	599, 203, 419			15. 00 16. 00
17. 00	01700 SOCI AL SERVI CE	Ö	o	077, 200, 117	30, 078		17.00
23. 00	02300 PARAMED ED PRGM-EMS	0	0	0	0	100	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		ما	47 01/ 007	15 570		20.00
30.00	03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT	0	0	47, 216, 237 11, 609, 906		0	
	04300 NURSERY	l o	o	10, 578, 295		0	1
44.00	04400 SKILLED NURSING FACILITY	0	o	0	0	0	44.00
FO 00	ANCILLARY SERVICE COST CENTERS	100	ما	112 005 025	0.272		F0 00
50. 00 50. 01	05000 OPERATING ROOM 05001 ENDOSCOPY	100	0	112, 095, 835 23, 322, 652		0	50.00
	05100 RECOVERY ROOM	l o	Ö	20, 004, 716		0	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	o	19, 960, 208	0	0	
	05300 ANESTHESI OLOGY	0	0	19, 494, 898		0	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI ATI ON-ONCOLOGY	0	0	45, 276, 116	0	0	54. 00 54. 01
56. 00	05600 RADI OI SOTOPE	Ö	o	Ö	o	0	56.00
56. 01	05601 NUCLEAR MEDICINE	o	o	0	o	0	56. 01
	05900 CARDI AC CATHETERI ZATI ON	0	0	51, 601, 046		0	59.00
60. 00 64. 00	06000   LABORATORY   06400   I NTRAVENOUS   THERAPY	0	0	93, 589, 981 0	0	0	60.00
65. 00	06500 RESPIRATORY THERAPY	Ö	o	18, 360, 305	o	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	6, 893, 118		0	66.00
67. 00 68. 00	O6700   OCCUPATI ONAL THERAPY   O6800   SPEECH PATHOLOGY	0	0	2, 664, 536		0	
69. 00	06900 ELECTROCARDI OLOGY	0	0	1, 650, 438 13, 047, 256	I	0	68. 00 69. 00
69. 01	06901 CARDI AC REHAB	0	o	1, 555, 184	O	0	69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	100	0	o	0	
73. 01	07301 ULTRA SOUND	0	o	0		0	73. 01
	07400 RENAL DIALYSIS 03950 WOUND CARE	0	0	657, 728	l .	0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	7, 685, 324 0		0	
	OUTPATIENT SERVICE COST CENTERS	-	-1	-	-1	•	]
	09000 CLINIC	0	0	01 000 (10	0	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	91, 939, 640	3, 084	100	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS						72.00
102. 00	10200 OPI OI D TREATMENT PROGRAM	0	0	O	0	0	102.00
110.00	SPECIAL PURPOSE COST CENTERS	100	100	F00 202 410	20.070	100	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	100	100	599, 203, 419	30, 078	100	118. 00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	C	0	0	192. 00
	19201 HEALTH TRACKS	0	o	O			192. 01
	07950   PRIMARY CARE CLINIC   07951   PARTNERS IN CARE	0	0	0			194.00
	07951 PARTNERS TN CARE 07952 OCCUPATI ONAL MEDI CI NE	0	0	0	-		194. 01 194. 02
194.03	07953 FOUNDATI ON	0	ō	0			194. 03
	07954 SCHOOL & TOWN CLINICS	0	0	0	0		194.04
	07955 MANAGED FACILITY 07956 RENTAL PROPERTIES	0	0	0	0		194. 05 194. 06
	07957 SNF NON CERTIFIED		0	0	0		194.06
200.00	Cross Foot Adjustments		Ĭ	· ·		9	200.00
201.00		4 005 055	. 044 041	0 / 40 0==	0.507.055	70, 00:	201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	4, 205, 999	6, 311, 046	2, 643, 301	3, 506, 037	786, 886	202.00
203. 00	l   '	42, 059. 990000	63, 110. 460000	0. 004411	116. 564831	7, 868. 860000	203.00
	· · · · · · · · · · · · · · · · · · ·						

Heal th I	Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provi der Co		Peri od: From 01/01/2022	Worksheet B-1	
					To 12/31/2022	Date/Time Pre 5/31/2023 12:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	PARAMED ED	
		SERVICES &	(100%	RECORDS &	SERVI CE	PRGM-EMS	
		SUPPLY	ALLOCATION)	LI BRARY	(TIME	(ASSI GNED	
		(100%		(C)	SPENT)	TIME)	
		ALLOCATION)					
		14. 00	15. 00	16. 00	17. 00	23. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	747, 231	354, 307	338, 00	79, 668	124, 098	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	7, 472. 310000	3, 543. 070000	0. 00056	2. 648713	1, 240. 980000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0. 000000	207. 00

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

				To 12/31/2022		pared:
		Ti +Lo	XVIII	Hospi tal	PPS	20 μιι
		11110	AVIII	Costs	FFJ	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
cost center bescription	(from Wkst.	Adj.	10141 00313	Di sal I owance	10141 00313	
	B, Part I,	Auj .		Di Sai i Owanice		
	col . 26)					
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	36, 801, 924		36, 801, 924	1 0	36, 801, 924	30.00
31.00 03100 INTENSIVE CARE UNIT	8, 051, 813		8, 051, 813		8, 051, 813	31.00
43. 00   04300 NURSERY	2, 985, 838		2, 985, 838		2, 985, 838	43.00
44.00 04400 SKILLED NURSING FACILITY	0	l e	,,		0	44.00
ANCILLARY SERVICE COST CENTERS	<u>'</u>	<u> </u>		<u>'</u>		ĺ
50. 00 05000 OPERATING ROOM	24, 338, 712		24, 338, 712	2 0	24, 338, 712	50.00
50. 01   05001   ENDOSCOPY	5, 370, 709		5, 370, 70	el ol	5, 370, 709	50. 01
51.00   05100   RECOVERY ROOM	6, 297, 626		6, 297, 626	o o	6, 297, 626	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 901, 557		6, 901, 55	0	6, 901, 557	52.00
53. 00   05300   ANESTHESI OLOGY	2, 506, 825		2, 506, 82	5 0	2, 506, 825	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	17, 199, 368		17, 199, 368	3 0	17, 199, 368	54.00
54. 01   05401   RADI ATI ON-ONCOLOGY	3, 666, 512		3, 666, 512	<u>2</u> 0	3, 666, 512	54. 01
56. 00   05600   RADI 0I SOTOPE	0		(	0	0	56.00
56. 01   05601 NUCLEAR MEDICINE	1, 003, 232		1, 003, 232	0	1, 003, 232	56. 01
59. 00   05900   CARDI AC   CATHETERI ZATI ON	4, 497, 282		4, 497, 282	2 이	4, 497, 282	59. 00
60. 00   06000   LABORATORY	18, 227, 507		18, 227, 50		18, 227, 507	60.00
64.00   06400   I NTRAVENOUS THERAPY	3, 316, 867		3, 316, 86		3, 316, 867	64.00
65. 00 06500 RESPI RATORY THERAPY	5, 636, 201	0	5, 636, 20°		5, 636, 201	65.00
66. 00 06600 PHYSI CAL THERAPY	12, 322, 914	0	12, 322, 91		12, 322, 914	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 534, 882	0	1, 534, 882		1, 534, 882	•
68. 00 06800 SPEECH PATHOLOGY	845, 053	0	845, 053		845, 053	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 724, 940	l .	2, 724, 940		2, 724, 940	69.00
69. 01   06901   CARDI AC   REHAB	1, 909, 555		1, 909, 55		1, 909, 555	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 898, 564		1, 898, 564	1 0	1, 898, 564	1
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0		14 (70 04)		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	14, 678, 241		14, 678, 24		14, 678, 241	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	40, 585, 529		40, 585, 529		40, 585, 529	73.00
73. 01   07301   ULTRA SOUND	1, 452, 734	l	1, 452, 734		1, 452, 734	•
74. 00   07400   RENAL DI ALYSI S 76. 00   03950   WOUND CARE	501, 475		501, 475		501, 475	•
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	2, 692, 141 0		2, 692, 14		2, 692, 141 0	76. 00 77. 00
OUTPATIENT SERVICE COST CENTERS	0			<u> </u>	0	77.00
90. 00 09000 CLI NI C	6, 568, 731		6, 568, 73	0	6, 568, 731	90.00
91. 00 09100 EMERGENCY	18, 328, 448		18, 328, 448		18, 328, 448	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 876, 227		6, 876, 22	7	6, 876, 227	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOID TREATMENT PROGRAM	0		(			102.00
200.00 Subtotal (see instructions)	259, 721, 407	0	207/721/10		259, 721, 407	
201.00 Less Observation Beds	6, 876, 227		6, 876, 22		6, 876, 227	
202.00 Total (see instructions)	252, 845, 180	0	252, 845, 180	이	252, 845, 180	202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-1		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Peri od:	Worksheet C	
		From 01/01/2022	Part I	

					rom 01/01/2022 o 12/31/2022	Part I Date/Time Pre	
			Ti +Lo	xVIII	Hospi tal	5/31/2023 12: PPS	20 pm
			Charges	AVIII	HOSPI tai	FF3	
	Cost Center Description	I npati ent	Outpati ent	Total (col 6	Cost or Other	TEFRA	
	oost center bescription	Impatront	outputtent	+ col . 7)	Ratio	Inpati ent	
				' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
I NPAT	TIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			·		
30.00 03000	ADULTS & PEDIATRICS	46, 011, 495		46, 011, 495			30.00
31.00 03100	INTENSIVE CARE UNIT	8, 824, 288		8, 824, 288			31.00
43.00 04300	NURSERY	10, 578, 295		10, 578, 295			43.00
44.00 04400	SKILLED NURSING FACILITY	0		C	ĺ		44.00
ANCI L	LARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	17, 495, 635	76, 014, 509			0. 000000	50.00
	ENDOSCOPY	1, 642, 226	21, 157, 749	22, 799, 975		0. 000000	50. 01
	RECOVERY ROOM	1, 914, 413	19, 149, 420	21, 063, 833	0. 298978	0. 000000	
	DELIVERY ROOM & LABOR ROOM	20, 615, 486	650, 926	21, 266, 412	0. 324529	0. 000000	52.00
	ANESTHESI OLOGY	5, 153, 946	21, 149, 979		0. 095302	0. 000000	53.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	16, 917, 506	96, 073, 141	112, 990, 647	0. 152219	0.000000	54.00
54. 01 05401	RADI ATI ON-ONCOLOGY	296, 548	44, 798, 190	45, 094, 738	0. 081307	0. 000000	54. 01
56.00 05600	RADI OI SOTOPE	0	0	C		0.000000	56.00
	NUCLEAR MEDICINE	725, 989	9, 326, 039			0. 000000	
	CARDIAC CATHETERIZATION	14, 444, 684	30, 057, 043			0. 000000	
	LABORATORY	23, 552, 187	86, 211, 053			0. 000000	
	INTRAVENOUS THERAPY	182, 706	32, 811, 085			0. 000000	
	RESPI RATORY THERAPY	7, 890, 164	4, 420, 526			0. 000000	
	PHYSI CAL THERAPY	2, 075, 026	19, 457, 798			0. 000000	
	OCCUPATI ONAL THERAPY	1, 435, 987	2, 506, 568		1	0. 000000	
4	SPEECH PATHOLOGY	599, 423	1, 763, 176			0. 000000	
4	ELECTROCARDI OLOGY	6, 168, 143	20, 528, 696			0. 000000	
	CARDI AC REHAB	14, 384	2, 880, 001			0. 000000	
	ELECTROENCEPHALOGRAPHY	199, 298	7, 276, 309			0. 000000	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0.000000	
	IMPL. DEV. CHARGED TO PATIENT	6, 764, 701	23, 348, 371			0.000000	
	DRUGS CHARGED TO PATIENTS	22, 508, 636	123, 658, 452			0.000000	
	ULTRA SOUND	2, 792, 804	10, 649, 147			0.000000	
	RENAL DIALYSIS	569, 283	88, 445			0.000000	
	WOUND CARE	282, 956	7, 402, 368			0.000000	
	ALLOGENEIC STEM CELL ACQUISITION THENT SERVICE COST CENTERS	0	0	C	0.000000	0. 000000	77. 00
	CLINIC	62, 719	42, 232, 660	42, 295, 379	0. 155306	0. 000000	90.00
	CLINIC   EMERGENCY	25, 425, 776	109, 347, 729			0.000000	
	OBSERVATION BEDS (NON-DISTINCT PART)	423, 006	5, 576, 834			0.000000	
	R REIMBURSABLE COST CENTERS	423,000	5, 570, 634	ا عرب کر کا	1. 140008	0.000000	72.00
	OPIOID TREATMENT PROGRAM		0				102.00
200. 00	Subtotal (see instructions)	245, 567, 710	-	1, 064, 103, 924			200.00
201.00	Less Observation Beds	243, 307, 710	010, 030, 214	1,004,103,924			200.00
202.00	Total (see instructions)	245, 567, 710	Q1Q 526 21 <i>1</i>	1, 064, 103, 924			201.00
202.00	Total (300 Histiactions)	243, 307, 710	010, 000, 214	1 1, 004, 103, 924	1		1202.00

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

INPATIENT ROUTINE SERVICE COST CENTERS   TITLE XVIII   Hospital   PPS   Ratio				10 12/31/2022	5/31/2023 12: 20 pm
INPATI ENT ROUTH INE SERVICE COST CENTERS   30.00   3000 ADULTS & PEDI ATRI CS   30.00   31.			Title XVIII	Hospi tal	
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   303000 ADULTS & PEDIATRIC S   31.00   31.00   31.00   31.00   11.00	Cost Center Description	PPS Inpatient			
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   31.		Ratio			
30.00   30000   ADULTS & PEDI ATRICS   31.00   31.00   31.00   1 NTENSIVE CARE UNIT   43.00   43.00   1 NTENSIVE CARE UNIT   43.00   43.00   1 NTENSIVE CARE UNIT   44.00   44.00   44.00   64.00		11. 00			
31.00   03100   INTENSIVE CARE UNIT					
43. 00   A4300   NURSERY					30.00
44. 00   A400   SKILLED NURSING FACILITY					
ANCI LLARY SERVICE COST CENTERS   50.00					43.00
50. 00   050000   05000   050000   050000   050000   050000   050000   0500000   050000   0500000   0500000   050000000   050000000   0500000000					44.00
50.01   OSD01   ENDOSCOPY   0.235588   50.01   ENDOSCOPY   0.5200   OSD01   REDUKERY ROOM   0.298978   51.00   0.208979   51.00   0.208979   0.2089799   0.2089799   0.2089799   0.20897999   0.2089799999999999999999999999999999999999					
51. 00   05100   RECOVERY ROOM   0.298978   51. 00   05200   DELIVERY ROOM & LABOR ROOM   0.324529   53. 00   05300   ANESTHESI OLOGY   0.995302   53. 00   05300   ANESTHESI OLOGY   0.995302   53. 00   054. 00   05400   RADII OLOGY-DI AGNOSTI C   0.152219   54. 00   05401   ROJAIN O-NOCOLOGY   0.081307   54. 01   05401   RADII ATIO NOCOLOGY   0.081307   54. 01   056. 00   05600   RADII OLOGY-DI AGNOSTI C   0.000000   56. 00   05600   RADII OLOGY-DI AGNOSTI C   0.000000   0.000000   0.00000   0.00000   0.00000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000					50.00
52, 00   05200   05200   05200   05200   05200   05200   05300   05300   05300   05300   05300   05300   05300   05300   05300   05300   05400   RADI OLOGY - DI AGNOSTI C   0.095302   0.005302   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000					
53. 00   05400   ABSTHESI OLOGY   0. 095302   53. 00					•
54. 00     05400 RADI OLOGY-DI AGNOSTI C     0. 152219     54. 01       54. 01     05401 RADI ATI ON-ONCOLOGY     0. 081307     55. 00       56. 00     05600 RADI OLOGY-DI AGNOSTI C     0. 000000     56. 00       56. 01     05601 NUCLEAR MEDI CI NE     0. 099804     56. 01       59. 00     05900 CARDIA C CATHETERI ZATI ON     0. 101059     59. 00       60. 00     06000 LABORATORY     0. 166062     60. 00       64. 00     064. 00     10 NITRAVENOUS THERAPY     0. 100530     66. 00       65. 00     06500 RESPI RATORY THERAPY     0. 457830     65. 00       66. 00     06600 PHYSI CAL THERAPY     0. 572285     66. 00       67. 00     06700 OCCUPATI ONAL THERAPY     0. 389311     67. 00       68. 00     06800 SPEECH PATHOLOGY     0. 387679     68. 00       69. 01     06900 LECTROCARDI OLOGY     0. 102070     69. 00       69. 01     06901 CARDIA CA REHAB     0. 659745     69. 00       70. 00     07000 LECTROENCEPHALOGRAPHY     0. 253968     70. 00       71. 00     07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS     0. 2000 CARDIA					
54. 01   05401   RADI ATI ON-ONCOLOGY   0. 081307   56. 00   05600   RADI OI SOTOPE   0. 000000   55. 00   0. 05600   RADI OI SOTOPE   0. 009804   56. 01   05601   NUCLEAR MEDI CI NE   0. 099804   56. 01   05601   NUCLEAR MEDI CI NE   0. 099804   56. 01   05601   NUCLEAR MEDI CI NE   0. 099804   56. 01   05600   RADI AC CATHETERI ZATI ON   0. 101059   59. 00   06000   LABORATORY   0. 160662   60. 00   06000   LABORATORY   0. 100530   64. 00   06400   INTRAVENOUS THERAPY   0. 100530   65. 00   06500   RESPI RATORY THERAPY   0. 457830   65. 00   06000   PHYSI CAL THERAPY   0. 572285   66. 00   06000   PHYSI CAL THERAPY   0. 389311   67. 00   06900   DECETROCARDI OLOGY   0. 389311   06. 00   06000   SPEECH PATHOLOGY   0. 357679   06. 00   06900   ELECTROCARDI OLOGY   0. 102070   069. 00   06900   ELECTROCARDI OLOGY   0. 102070   07000   ELECTROCARDI OLOGY   0. 253968   70. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 000000   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 267665   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 277665   73. 01   07301   ULTRA SOUND   0. 108075   73. 01   07301   ULTRA SOUND   0. 108075   73. 01   07301   ULTRA SOUND   0. 108075   73. 01   07700   ALLOGENEIC STEM CELL ACQUISITION   0. 000000   07700   ALLOGENEIC STEM CELL ACQUISITION   0. 03509   WOUND CAPE   0. 000000   07700   ALLOGENEIC STEM CELL ACQUISITION   0. 000000   07700   ALLOGENEIC STEM CELL ACQUISITION   0. 0135994   91. 00   09000   CLINIC REGION   0. 155306   90. 00   09000   CLINIC REGION   0. 155306   90. 00   09000   0. 1011   0. 000000   0. 10100   DREATMENT PROGRAM   0. 155306   90. 00   0. 000000   0. 000000   0. 00000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 000000   0. 0000000   0. 00000000	53. 00   05300   ANESTHESI OLOGY	0. 095302			53.00
56. 00     05600 RS600 RADI OI SOTOPE     0.0000000       56. 01     056001 NUCLEAR MEDI CI NE     0.099804       59. 00     05900 CARDI AC CATHETERI ZATI ON     0.101059       60. 00     06000 LABORATORY     0.166062       64. 00     06400 INTRAVENOUS THERAPY     0.100530       65. 00     06500 RESPI RATORY THERAPY     0.457830       66. 00     06600 PHYSI CAL THERAPY     0.572285       67. 00     06700 OCCUPATI ONAL THERAPY     0.389311       68. 00     06800 SPEECH PATHOLOGY     0.357679       69. 00     06900 LECTROCARDI OLOGY     0.10270       69. 01     06901 CARDI AC REHAB     0.659745       70. 00     07000 MEDICAL SUPPLIES CHARGED TO PATIENTS     0.00000       71. 00     07100 MEDICAL SUPPLIES CHARGED TO PATIENTS     0.273665       73. 01     07301 IUTRA SOUND     0.487438       74. 00     07400 RENAL DI ALYSI S     0.277665       76. 00     03950 WOUND CARE     0.35606       77. 00     000000 CLI NI C     0.185306       09000 CLI NI C     0.155306       09100 EMERGENCY     0.155306       09100 DSERVATI ON BEDS (NON-DI STI NCT PART)     0.135994       102. 00     09000 CLI NI C     0.155306       09100 DSERVATI ON BEDS (NON-DI STI NCT PART)     0.135994 <t< td=""><td>54. 00   05400   RADI OLOGY-DI AGNOSTI C</td><td>0. 152219</td><td></td><td></td><td>54.00</td></t<>	54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 152219			54.00
56. 01       05601 NUCLEAR MEDICINE       0.099804       56. 01         59. 00       05900 CARDIAC CATHETERIZATION       0.101059       59. 00         64. 00       06400 INTRAVENOUS THERAPY       0.166062       60. 00         65. 00       06500 RESPIRATORY THERAPY       0.457830       65. 00         66. 00       06600 PHYSI CAL THERAPY       0.572285       66. 00         67. 00       06700 OCCUPATIONAL THERAPY       0.389311       67. 00         68. 00       06800 SPECH PATHOLOGY       0.357679       69. 00         69. 01       06900 ELECTROCARDI OLOGY       0.102070       69. 00         69. 01       06901 CARDI AC REHAB       0.557245       69. 01         71. 00       07100 ELECTROCEPHALOGRAPHY       0.253968       79. 00         72. 00       07200 IMPL. DEV. CHARGED TO PATIENTS       0.000000       70. 00         73. 01       07300 IMPL. DEV. CHARGED TO PATIENT       0.487438       72. 00         73. 01       07300 IMPL. DEV. CHARGED TO PATIENTS       0.277665       73. 00         74. 00       07400 RENAL DI ALYSIS       0.762435       74. 00         77. 00       07700 IALOGENEI C STEM CELL ACQUI SI TI ON       0.000000       77. 00         09000 OBSERVATI ON BEDS (NON-DI STINCT PART) <td< td=""><td>54. O1   05401   RADI ATI ON-ONCOLOGY</td><td>0. 081307</td><td></td><td></td><td>54. 01</td></td<>	54. O1   05401   RADI ATI ON-ONCOLOGY	0. 081307			54. 01
59. 00   05900   CARDI AC CATHETERI ZATI ON   0. 101059   0. 166062   60. 00   06000   LABORATORY   0. 1606062   60. 00   06. 00   06.000   RESPI RATORY THERAPY   0. 100530   65. 00   06500   RESPI RATORY THERAPY   0. 457830   65. 00   06. 00   06.000   PHYSI CAL THERAPY   0. 572285   66. 00   06. 00   06.000   PHYSI CAL THERAPY   0. 572285   66. 00   06. 00   06.000   CARDITI ONAL THERAPY   0. 389311   06. 00   06. 00   06.000   ELECTROCARDIO LOGY   0. 357679   08. 00   06. 00   06.000   ELECTROCARDIO LOGY   0. 102070   06. 00   06.000   ELECTROCARDIO LOGY   0. 102070   06. 00   06.000   ELECTROCARDIO LOGY   0. 253968   06. 00   07.000   ELECTROCARDIO LOGY   0. 253968   07. 00   07.000   ELECTROENCEPHALOGRAPHY   0. 253968   07. 00   07.000   ELECTROENCEPHALOGRAPHY   0. 253968   07. 00   07.000   ELECTROENCEPHALOGRAPHY   0. 253968   07. 00   07.000   ENUGS CHARGED TO PATIENTS   0. 0000000   07.000   EVL CHARGED TO PATIENTS   0. 0000000   07.000   DRUGS CHARGED TO PATIENTS   0. 277665   0. 350.000   07.000   DRUGS CHARGED TO PATIENTS   0. 0000000   07.000   DRUGS CHARGED TO PATIENTS   0. 0000000   07.000   07.000   DRUGS CHARGED TO PATIENTS   0. 0000000   07.000	56. 00   05600 RADI 0I SOTOPE	0. 000000			56.00
60. 00   06000   LABORATORY   0. 166062   66. 00   06400   INTRAVENOUS THERAPY   0. 100530   66. 00   06500   RESPI RATORY THERAPY   0. 457830   65. 00   06500   RESPI RATORY THERAPY   0. 572285   66. 00   06600   PHYSI CAL THERAPY   0. 572285   66. 00   06600   PHYSI CAL THERAPY   0. 389311   67. 00   06800   SPEECH PATHOLOGY   0. 357679   68. 00   06800   SPEECH PATHOLOGY   0. 102070   069. 00   06900   ELECTROCARDI OLOGY   0. 102070   69. 01   06900   ELECTROCARDI OLOGY   0. 0579745   69. 01   07000   ELECTROCARDI OLOGY   0. 059745   69. 01   07000   ELECTROCARDI OLOGY   0. 059745   0. 07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 000000   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 000000   072. 00   07300   MRUL DEV. CHARGED TO PATI ENTS   0. 277665   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 277665   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 277665   73. 00   07301   ULTRA SOUND   0. 108075   73. 01   07301   ULTRA SOUND   0. 108075   74. 00   07400   RENAL DI ALYSIS   0. 762435   74. 00   07500   ALLOGENEIC STEM CELL ACQUISITION   0. 0000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	56. 01   05601 NUCLEAR MEDICINE	0. 099804			56. 01
64. 00   06400   INTRAVENOUS THERAPY   0. 100530   64. 00   06500   RESPI RATORY THERAPY   0. 457830   65. 00   66. 00   06500   RESPI RATORY THERAPY   0. 457830   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 389311   67. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0. 389311   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 357679   68. 00   06900   LECTROCARDI OLOGY   0. 102070   06901   CARDI AC REHAB   0. 659745   69. 01   06901   CARDI AC REHAB   0. 659745   69. 01   07000   ELECTROCENCEPHALOGRAPHY   0. 253968   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 000000   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 487438   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 277665   73. 01   07301   ULTRA SOUND   0. 108075   73. 01   07400   RENAL DI ALYSI S   0. 762435   74. 00   07400   RENAL DI ALYSI S   0. 762435   74. 00   07400   RENAL DI ALYSI S   0. 350296   76. 00   07500   ALLOGENE IC STEM CELL ACQUI SI TI ON   0. 000000   0. 1055306   91. 00   09900   CLI NI C   0. 155306   91. 00   09900   EMERGENCY   0. 135994   91. 00   09900   DRUGS CHARGED TO PATI ENTS   0. 135994   91. 00   09900   DRUGS CHARGEN CENTERS   0. 12500	59. 00   05900 CARDI AC CATHETERI ZATI ON	0. 101059			59.00
65. 00   06500   RESPIRATORY THERAPY   0.457830   65. 00   66.00   06600   PHYSI CAL THERAPY   0.572285   66. 00   66.00   06700   0CCUPATI ONAL THERAPY   0.389311   67. 00   06800   SPEECH PATHOLOGY   0.357679   68. 00   06800   SPEECH PATHOLOGY   0.102070   69. 00   69.	60. 00   06000   LABORATORY	0. 166062			60.00
66. 00   06600   PHYSI CAL THERAPY   0. 572285   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0. 389311   67. 00   68. 00   68. 00   68. 00   68. 00   69. 00   69. 01	64.00 06400 INTRAVENOUS THERAPY	0. 100530			64.00
67. 00   06700   0CCUPATI ONAL THERAPY   0. 389311   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 357679   68. 00   69. 01   06900   ELECTROCARDI OLOGY   0. 102070   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 253968   70. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0. 000000   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 277665   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 277665   73. 00   73. 01   07301   ULTRA SOUND   0. 108075   73. 01   74. 00   07400   RENAL DI ALYSI S   0. 762435   74. 00   76. 00   03950   WOUND CARE   0. 350296   77. 00   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0. 000000   77. 00   00700   CLI NI C   0. 155306   90. 00   90. 00   09000   CLI NI C   0. 155306   91. 00   91. 00   09100   EMERGENCY   0. 135994   92. 00   92. 00   0000   OPI OL TREATMENT PROGRAM   102. 00   92. 00   OTHER REIMBURSABLE COST CENTERS   102. 00   920. 00   Subtotal (see instructions)   200. 00   9201. 00   Less Observation Beds   201. 00	65. 00 06500 RESPIRATORY THERAPY	0. 457830			65.00
68. 00   06800   SPEECH PATHOLOGY   0. 357679   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0. 102070   69. 00   69. 01   06901   CARDI AC REHAB   0. 659745   69. 01   06901   CARDI AC REHAB   0. 659745   69. 01   07000   ELECTROENCEPHALOGRAPHY   0. 253968   70. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 000000   71. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 487438   72. 00   07300   DRUGS CHARGED TO PATIENTS   0. 277665   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 277665   73. 00   07400   RENAL DI ALYSI S   0. 762435   74. 00   07400   RENAL DI ALYSI S   0. 762435   74. 00   07400   RENAL DI ALYSI S   0. 350296   76. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 00000000	66. 00   06600 PHYSI CAL THERAPY	0. 572285			66.00
69. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0. 389311			67.00
69. 01 06901 CARDI AC REHAB 0. 659745 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 253968 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0. 487438 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENT 0. 277665 73. 00 73. 01 07301 ULTRA SOUND 0. 108075 73. 01 74. 00 07400 RENAL DI ALYSI S 0. 762435 74. 00 76. 00 03950 WOUND CARE 0. 350296 76. 00 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0. 000000 77. 00 0UTPATI ENT SERVI CE COST CENTERS 90. 09000 CLI NI C 0. 135994 91. 00 91. 00 09100 EMERGENCY 0. 135994 91. 00 92. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 1. 146068 92. 00 0THER REI MBURSABLE COST CENTERS 92. 00 0000 Subtotal (see instructions) Less Observati on Beds 201. 00	68. 00 06800 SPEECH PATHOLOGY	0. 357679			68.00
70.00   07000   ELECTROENCEPHALOGRAPHY   0.253968   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.000000   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENT   0.487438   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0.277665   73.00   73.01   ULTRA SOUND   0.108075   73.01   07400   RENAL DIALYSIS   0.3762435   74.00   07400   RENAL DIALYSIS   0.350296   76.00   03950   WOUND CARE   0.350296   76.00   07700   ALLOGENEIC STEM CELL ACQUISITION   0.000000   000000   000000   000000   000000	69. 00 06900 ELECTROCARDI OLOGY	0. 102070			69.00
71. 00	69. 01   06901   CARDI AC   REHAB	0. 659745			69. 01
72. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 253968			70.00
73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
73. 01	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 487438			72.00
74. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 277665			73.00
76. 00	73. 01 07301 ULTRA SOUND	0. 108075			73. 01
76. 00	74. 00 07400 RENAL DIALYSIS	0. 762435			74.00
OUTPATIENT SERVICE COST CENTERS   90.00   09000   CLINIC   0.155306   90.00   91.00   09100   EMERGENCY   0.135994   91.00   92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   1.146068   92.00   09200   09101   DTREATMENT PROGRAM   102.00   10200   09101   DTREATMENT PROGRAM   102.00   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00	76. 00 03950 WOUND CARE	0. 350296			76.00
OUTPATIENT SERVICE COST CENTERS   90.00   09000   CLINIC   0.155306   90.00   91.00   09100   EMERGENCY   0.135994   91.00   92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   1.146068   92.00   09200   09101   DTREATMENT PROGRAM   102.00   10200   09101   DTREATMENT PROGRAM   102.00   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00	77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77.00
91. 00   09100   EMERGENCY   0.135994   1.146068   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   1.146068   092.00   OTHER REIMBURSABLE COST CENTERS   102. 00   10200   OPI OI D TREATMENT PROGRAM   102. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00	OUTPATIENT SERVICE COST CENTERS				
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   1.146068   92. 00     102. 00   10200   0PI OI D TREATMENT PROGRAM   102. 00     200. 00   Subtotal (see instructions)   200. 00     201. 00   Less Observation Beds   201. 00	90. 00 09000 CLI NI C	0. 155306			90.00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   1.146068   92. 00     102. 00   10200   0PI OI D TREATMENT PROGRAM   102. 00     200. 00   Subtotal (see instructions)   200. 00     201. 00   Less Observation Beds   201. 00					91.00
OTHER REIMBURSABLE COST CENTERS           102.00         10200         OPI OI D TREATMENT PROGRAM         102.00           200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 146068			92.00
102.00       10200       OPIOID TREATMENT PROGRAM       102.00         200.00       Subtotal (see instructions)       200.00         201.00       Less Observation Beds       201.00		<u> </u>			
201.00 Less Observation Beds 201.00					102.00
	200.00 Subtotal (see instructions)				
	201.00 Less Observation Beds				201. 00
2021 00	202.00 Total (see instructions)				202. 00

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

				rom 01/01/2022 o 12/31/2022	Part I Date/Time Pre 5/31/2023 12:	
		Ti tl	e XIX	Hospi tal	Cost	20 piii
		11 (1	C ALK	Costs	0031	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
oost center bescription	(from Wkst.	Adj.	10141 00313	Di sal I owance	10141 00313	
	B, Part I,	/ ray .		Di Sai i Gwariec		
	col. 26)					
	1, 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	11.00	2.00	0.00	1. 00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	36, 801, 924		36, 801, 924	0	36, 801, 924	30.00
31. 00   03100   NTENSI VE CARE UNI T	8, 051, 813		8, 051, 813		8, 051, 813	
43. 00   04300   NURSERY	2, 985, 838		2, 985, 838	1	2, 985, 838	
44.00 04400 SKILLED NURSING FACILITY	2, 700, 000		2, 700, 000		2, 700, 000	1
ANCI LLARY SERVICE COST CENTERS				,ı	0	1 44.00
50. 00 05000 OPERATING ROOM	24, 338, 712		24, 338, 712	. 0	24, 338, 712	50.00
50. 01   05001   ENDOSCOPY	5, 370, 709	l .	5, 370, 709		5, 370, 709	50. 01
51. 00   05100   RECOVERY ROOM	6, 297, 626	l .	6, 297, 626		6, 297, 626	
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 901, 557		6, 901, 557		6, 901, 557	52.00
53. 00   05300   ANESTHESI OLOGY	2, 506, 825		2, 506, 825		2, 506, 825	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	17, 199, 368	l .	17, 199, 368		17, 199, 368	
54. 01   05401   RADI ATI ON-ONCOLOGY	3, 666, 512		3, 666, 512		3, 666, 512	54. 01
56. 00   05600   RADI OI SOTOPE	3,000,312		3,000,312		3, 000, 312	56.00
56. 01   05601 NUCLEAR MEDICINE	1, 003, 232		1, 003, 232	1	1, 003, 232	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 497, 282		4, 497, 282		4, 497, 282	59.00
60. 00   06000   LABORATORY	18, 227, 507	l .	18, 227, 507		18, 227, 507	60.00
64. 00 06400 I NTRAVENOUS THERAPY	3, 316, 867		3, 316, 867		3, 316, 867	64.00
65. 00 06500 RESPIRATORY THERAPY	5, 636, 201				5, 636, 201	65.00
66. 00   06600   PHYSI CAL THERAPY	12, 322, 914				12, 322, 914	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 534, 882	l .	1, 534, 882		1, 534, 882	67.00
68. 00 06800 SPEECH PATHOLOGY	845, 053		845, 053		845, 053	68.00
69. 00   06900   ELECTROCARDI OLOGY	2, 724, 940		2, 724, 940		2, 724, 940	69.00
69. 01   06901   CARDI AC   REHAB	1, 909, 555	l .	1, 909, 555		1, 909, 555	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 898, 564		1, 898, 564		1, 898, 564	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,070,304		1, 070, 304	1	1, 070, 304	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	14, 678, 241		14, 678, 241	-	14, 678, 241	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	40, 585, 529		40, 585, 529		40, 585, 529	73.00
73. 00 07300 DRUGS CHARGED TO PATTENTS  73. 01 07301 ULTRA SOUND	1, 452, 734	l .	1, 452, 734		1, 452, 734	73.00
74. 00   07400   RENAL DI ALYSI S	501, 475		501, 475		501, 475	
76. 00 03950 WOUND CARE	2, 692, 141		2, 692, 141		2, 692, 141	76.00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	2,092,141	l .	2, 092, 141		2, 092, 141	1
OUTPATIENT SERVICE COST CENTERS	0			, O	U	77.00
90. 00 09000 CLINIC	6, 568, 731		6, 568, 731	0	6, 568, 731	90.00
91. 00   09100   EMERGENCY	18, 328, 448		18, 328, 448		18, 328, 448	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 876, 227		6, 876, 227		6, 876, 227	1
OTHER REIMBURSABLE COST CENTERS	0,070,227		0,070,227		0,070,227	72.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0				0	102.00
200.00 Subtotal (see instructions)	259, 721, 407		-		-	
201.00 Less Observation Beds	6, 876, 227	l .	6, 876, 227		6, 876, 227	201 00
202. 00 Total (see instructions)	252, 845, 180	l .				
232. 33	202,010,100	,	202,010,100	۰, ۱	202, 010, 100	1202.00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Peri od: From 01/01/2022	Worksheet C	
		11011101170172022		

					rom 01/01/2022 o 12/31/2022	Part I Date/Time Pre 5/31/2023 12:	
			Ti tl	e XIX	Hospi tal	Cost	20 piii
			Charges	5 7.17.	l loopi tui	3551	
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		,		+ col . 7)	Ratio	Inpatient	
				,		Ratio	
		6. 00	7.00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	46, 011, 495		46, 011, 495			30.00
31.00	03100 INTENSIVE CARE UNIT	8, 824, 288		8, 824, 288		ļ	31.00
43.00	04300 NURSERY	10, 578, 295		10, 578, 295			43.00
44.00	04400 SKILLED NURSING FACILITY	0		C			44.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	17, 495, 635	76, 014, 509			0.000000	50.00
	05001 ENDOSCOPY	1, 642, 226	21, 157, 749	22, 799, 975		0.000000	50. 01
	05100 RECOVERY ROOM	1, 914, 413	19, 149, 420			0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	20, 615, 486	650, 926			0.000000	52.00
53.00	05300 ANESTHESI OLOGY	5, 153, 946	21, 149, 979			0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	16, 917, 506	96, 073, 141			0.000000	54.00
54. 01	05401 RADI ATI ON-ONCOLOGY	296, 548	44, 798, 190			0.000000	54. 01
56. 00	05600 RADI OI SOTOPE	0	0	-	0.00000	0.000000	56.00
56. 01	05601 NUCLEAR MEDICINE	725, 989	9, 326, 039			0. 000000	56. 01
59. 00	05900 CARDI AC CATHETERI ZATI ON	14, 444, 684	30, 057, 043		0. 101059	0.000000	59. 00
60.00	06000 LABORATORY	23, 552, 187	86, 211, 053			0.000000	60.00
64. 00	06400 I NTRAVENOUS THERAPY	182, 706	32, 811, 085		0. 100530	0. 000000	64.00
65. 00	06500 RESPI RATORY THERAPY	7, 890, 164	4, 420, 526		1	0. 000000	65.00
66. 00	06600 PHYSI CAL THERAPY	2, 075, 026	19, 457, 798			0. 000000	66.00
	06700 OCCUPATI ONAL THERAPY	1, 435, 987	2, 506, 568			0. 000000	67.00
68. 00	06800 SPEECH PATHOLOGY	599, 423	1, 763, 176			0. 000000	68.00
69.00	06900 ELECTROCARDI OLOGY	6, 168, 143	20, 528, 696			0. 000000	69.00
69. 01	06901 CARDI AC REHAB	14, 384	2, 880, 001	2, 894, 385		0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	199, 298	7, 276, 309			0.000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	-	0.00000	0.000000	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	6, 764, 701 22, 508, 636	23, 348, 371			0.000000	72. 00 73. 00
	07300 DRUGS CHARGED TO PATTENTS	2, 792, 804	123, 658, 452 10, 649, 147			0. 000000 0. 000000	73.00
	07400 RENAL DIALYSIS	569, 283	88, 445			0.000000	74.00
	03950 WOUND CARE	282, 956	7, 402, 368			0.000000	76.00
	07700 ALLOGENEIC STEM CELL ACQUISITION	202, 930	7, 402, 300			0. 000000	77.00
77.00	OUTPATIENT SERVICE COST CENTERS	0	0		0.000000	0.000000	77.00
90.00	09000 CLINIC	62, 719	42, 232, 660	42, 295, 379	0. 155306	0. 000000	90.00
	09100 EMERGENCY	25, 425, 776	109, 347, 729			0. 000000	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	423, 006	5, 576, 834			0. 000000	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	120,000	0,070,001	0, 777, 010	1. 1 10000	0.00000	72.00
102.00	10200 OPLOLD TREATMENT PROGRAM	0	0				102.00
200. 00		245, 567, 710	-	1, 064, 103, 924		ļ	200.00
201. 00	1 ,		2.2,000,211	, == ., .55, ,2			201.00
202. 00		245, 567, 710	818, 536, 214	1, 064, 103, 924	.		202.00
					'		

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

				10 12/31/2022	5/31/2023 12: 2	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient		<u> </u>		
	·	Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
43.00	04300 NURSERY					43.00
44.00	04400 SKILLED NURSING FACILITY					44.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0. 000000				50.00
	05001 ENDOSCOPY	0. 000000				50. 01
	05100 RECOVERY ROOM	0. 000000				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0.000000				54.00
54. 01	05401 RADI ATI ON-ONCOLOGY	0. 000000				54.01
56.00	05600 RADI OI SOTOPE	0.000000				56.00
56. 01	05601 NUCLEAR MEDICINE	0. 000000				56.01
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60.00	06000 LABORATORY	0. 000000				60.00
64.00	06400 INTRAVENOUS THERAPY	0. 000000				64.00
65.00	06500 RESPIRATORY THERAPY	0. 000000				65.00
66.00	06600 PHYSI CAL THERAPY	0.000000				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00	06800 SPEECH PATHOLOGY	0.000000				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69.00
69. 01	06901 CARDI AC REHAB	0. 000000				69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
73.01	07301 ULTRA SOUND	0. 000000				73.01
74.00	07400 RENAL DIALYSIS	0. 000000				74.00
76.00	03950 WOUND CARE	0. 000000				76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77.00
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C	0. 000000				90.00
	09100 EMERGENCY	0. 000000				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
	OTHER REIMBURSABLE COST CENTERS					
	10200 OPI OI D TREATMENT PROGRAM					102.00
200.00	,					200. 00
201.00	l					201. 00
202. 00	Total (see instructions)					202. 00

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		narodi
				10 12/31/2022	Date/Time Pre 5/31/2023 12:	pareu: 20 nm
		Title	XVIII	Hospi tal	PPS	20 р
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	4, 633, 142	0	4, 633, 14			30.00
31.00   INTENSIVE CARE UNIT	598, 326		598, 32	2, 693	222. 18	31.00
43. 00 NURSERY	124, 657		124, 65	7 1, 906	65. 40	
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00
200.00 Total (lines 30 through 199)	5, 356, 125		5, 356, 12	5 27, 768		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)	1			
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	5, 810					30.00
31.00 INTENSIVE CARE UNIT	841	186, 853	1			31.00
43. 00 NURSERY	0	0	)			43.00
44.00 SKILLED NURSING FACILITY	0	0	)			44.00
200.00 Total (lines 30 through 199)	6, 651	1, 348, 679	1			200. 00

Health Financial Systems	HENDRI CKS REG	I ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Pre 5/31/2023 12:	pared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cos to Charges (col. 1 ÷ col. 2)		Capital Costs (column 3 x column 4)	
	1. 00	2.00	3.00	4. 00	5. 00	

			litle	XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col. 2)			
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 002, 942			6, 705, 385	143, 629	50.00
50. 01	05001 ENDOSCOPY	1, 078, 340			435, 023	20, 575	
	05100 RECOVERY ROOM	1, 323, 480			956, 317	60, 087	
52.00	05200 DELIVERY ROOM & LABOR ROOM	598, 113			0	0	52.00
53.00	05300 ANESTHESI OLOGY	100, 999			1, 597, 381	6, 134	53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	1, 583, 112		0. 014011	6, 465, 010		54.00
54. 01	05401 RADI ATI ON-ONCOLOGY	499, 086	45, 094, 738		127, 777	1, 414	
56.00	05600  RADI 0I SOTOPE	0	0	0. 000000	0	0	56.00
56. 01	05601   NUCLEAR MEDICINE	33, 871	10, 052, 028	0. 003370	319, 481	1, 077	56. 01
59. 00	05900  CARDI AC CATHETERI ZATI ON	491, 482		0. 011044	3, 896, 526		59.00
60.00	06000 LABORATORY	789, 234	109, 763, 240		6, 767, 814		
64. 00	06400 I NTRAVENOUS THERAPY	254, 631	32, 993, 791	0. 007718	9, 957		64.00
65.00	06500 RESPI RATORY THERAPY	394, 890			1, 749, 535	56, 120	65.00
66.00	06600 PHYSI CAL THERAPY	888, 554	21, 532, 824	0. 041265	924, 087	38, 132	66.00
67.00	06700 OCCUPATI ONAL THERAPY	355, 399	3, 942, 555	0. 090144	583, 237	52, 575	67.00
68.00	06800 SPEECH PATHOLOGY	114, 210	2, 362, 599	0. 048341	203, 157	9, 821	68.00
69. 00	06900 ELECTROCARDI OLOGY	236, 654	26, 696, 839	0. 008864	2, 392, 870	21, 210	69.00
69. 01	06901 CARDI AC REHAB	223, 634	2, 894, 385	0. 077265	2, 960	229	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	310, 880	7, 475, 607	0. 041586	71, 208	2, 961	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	80, 351	30, 113, 072	0. 002668	3, 206, 984	8, 556	72.00
	07300 DRUGS CHARGED TO PATIENTS	541, 931	146, 167, 088	0.003708	6, 227, 718	23, 092	73.00
73. 01	07301 ULTRA SOUND	148, 743	13, 441, 951	0. 011066	957, 600	10, 597	73. 01
74.00	07400 RENAL DIALYSIS	3, 615	657, 728	0. 005496	175, 627	965	74.00
76.00	03950 WOUND CARE	22, 921	7, 685, 324	0. 002982	17, 492	52	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	761, 830	42, 295, 379	0. 018012	0	0	90.00
91.00	09100 EMERGENCY	1, 663, 309	134, 773, 505	0. 012342	8, 215, 003	101, 390	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	865, 676	5, 999, 840	0. 144283	387, 351	55, 888	92.00
200.00	Total (lines 50 through 199)	15, 367, 887	998, 689, 846		52, 395, 500	796, 856	200. 00

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE (	OTHER PASS THROUGH COS		F	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/31/2023 12:	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown		Medi cal	
	Post-Stepdown	Ü	Adjustments		Educati on	
	Adjustments		1		Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTER	S					
30. 00 03000 ADULTS & PEDIATRICS	0	0	(	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	lol	0		0	0	31.00
43. 00 04300 NURSERY	l ol	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	l ol	0		0		44.00
200.00 Total (lines 30 through 199)		0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	Inpatient	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)	3 3	
		minus col. 4)		,		
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTER	S					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	23, 169	0.00	5, 810	30.00
31.00 03100 INTENSIVE CARE UNIT		0	2, 693	0.00	841	31.00
43. 00 04300 NURSERY	1	0	1, 906		0	43.00
44.00 04400 SKILLED NURSING FACILITY	1	0		0.00	0	44.00
200.00 Total (lines 30 through 199)		0	27, 768	3	6, 651	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTER	S					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
43. 00   04300 NURSERY	o					43.00
44.00 04400 SKILLED NURSING FACILITY	o					44.00
200.00 Total (lines 30 through 199)	o					200.00
	'					•

Health Financial Systems	HENDRICKS REGION	AL HEALTH	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0005	From 01/01/2022	Worksheet D Part IV Date/Time Prepared

					10 12/31/2022	5/31/2023 12:	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	'	Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
50. 01	05001 ENDOSCOPY	0	0		0	0	50. 01
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	o	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	o	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	0		0 0	0	54.00
54. 01	05401 RADI ATI ON-ONCOLOGY	l ol	0		0 0	0	54. 01
56. 00	05600 RADI 0I SOTOPE	o	0		0	0	56.00
56. 01	05601 NUCLEAR MEDICINE	l ol	0		0	0	56. 01
	05900 CARDI AC CATHETERI ZATI ON	l ol	0		0	0	59.00
	06000 LABORATORY	l ol	0		0	0	60.00
	06400 I NTRAVENOUS THERAPY	l ol	0		0	0	64.00
	06500 RESPI RATORY THERAPY	l ol	0		0	0	65.00
	06600 PHYSI CAL THERAPY	l ol	0		0	0	66.00
	06700 OCCUPATI ONAL THERAPY	أما	0		0	0	67. 00
	06800 SPEECH PATHOLOGY	أما	0		0	0	68.00
	06900 ELECTROCARDI OLOGY	l ol	0		0	0	69. 00
	06901 CARDI AC REHAB		0		0	l o	69. 01
	07000 ELECTROENCEPHALOGRAPHY		0		0	l o	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		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
	07301 ULTRA SOUND		0		0	0	73. 01
	07400 RENAL DIALYSIS		0		0	0	74.00
	03950 WOUND CARE		0		0 0	0	76.00
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	· -	1
	OUTPATIENT SERVICE COST CENTERS	<u> </u>			0	·	1 , ,
	09000 CLINIC	ol	0		0 0	0	90.00
	09100 EMERGENCY		0			786, 886	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	ا	O		ol o	0	92.00
200.00	,		0		o o	ľ	1
200.00	1.0 ta. (111103 00 till odgil 177)	١	O	I	٥,	, , , , , , , , , , , , , , , , , , , ,	1-30.00

Health Financial Systems	HENDRI CKS REGION	IAL HEALTH	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0005	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2022	Part IV

THROUG	H COSTS				o 12/31/2022		
			Title	e XVIII	Hospi tal	PPS	20 piii
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	, and the second	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			·	and 4)	·	(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	_	1		0. 000000	
	05001 ENDOSCOPY	0	0	) C		0. 000000	1
	05100  RECOVERY ROOM	0	0	) C	,,		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	) C	21, 266, 412	0.000000	
53.00	05300 ANESTHESI OLOGY	0	0	) C	20,000,720	0. 000000	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	, ,	0. 000000	
54. 01	05401 RADI ATI ON-ONCOLOGY	0	0	) C	45, 094, 738		
56.00	05600 RADI OI SOTOPE	0	0	) C		0. 000000	
56. 01	05601 NUCLEAR MEDICINE	0	0	1	, ,	0. 000000	1
59. 00	05900  CARDI AC CATHETERI ZATI ON	0	0	1	, ,	0. 000000	
60.00	06000 LABORATORY	0	0	1			
	06400 I NTRAVENOUS THERAPY	0	0	) C	,	0. 000000	
65.00	06500 RESPI RATORY THERAPY	0	0	) C	12, 310, 690		
66. 00	06600 PHYSI CAL THERAPY	0	0	1	21, 532, 824	0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	0, , , _, 000	0. 000000	
	06800 SPEECH PATHOLOGY	0	0	1	_, -, -, -, -, -,		1
	06900 ELECTROCARDI OLOGY	0	0	1	,,		1
	06901 CARDI AC REHAB	0	0	1	2,0,1,000	0. 000000	1
	07000 ELECTROENCEPHALOGRAPHY	0	0	1	.,,	0. 000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	1	0. 000000	
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	1		0. 000000	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	C			1
	07301 ULTRA SOUND	0	0	C	1 .0,, ,0.	0. 000000	1
	07400 RENAL DI ALYSI S	0	0	1			1
	03950 WOUND CARE	0			,	0. 000000	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	<u>C</u>	0	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						1
	09000 CLI NI C	0					
	09100 EMERGENCY	0				0. 005839	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1	-, ,		
200.00	Total (lines 50 through 199)	0	786, 886	786, 886	998, 689, 846	ı	200. 00

Health Financial Systems	HENDRICKS REGION	AL HEALTH	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provi der CCN: 15-0005	From 01/01/2022	Worksheet D Part IV Date/Time Prepared: 5/31/2023 12:20 pm
		T: +1 a V/////	Heeni tel	DDC

			To	12/31/2022	Date/Time Pre 5/31/2023 12:	
		Title	XVIII	Hospi tal	PPS	20 μιι
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
oost conten bescription	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	onal ges	Costs (col. 8	orial ges	Costs (col. 9	
	col. 7)		x col. 10)		x col . 12)	
	9.00	10. 00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	6, 705, 385	0	14, 019, 579	0	50.00
50. 01 05001 ENDOSCOPY	0. 000000	435, 023	0	4, 968, 385	0	50. 01
51.00 05100 RECOVERY ROOM	0. 000000	956, 317	0	4, 214, 866	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000	1, 597, 381	0	4, 782, 622	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	6, 465, 010	0	17, 948, 275	0	54.00
54. 01   05401   RADI ATI ON-ONCOLOGY	0. 000000	127, 777	0	13, 558, 979	0	54. 01
56. 00   05600 RADI OI SOTOPE	0. 000000	0	0	0	0	56.00
56. 01   05601 NUCLEAR MEDICINE	0. 000000	319, 481	0	2, 613, 305	0	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	3, 896, 526	0	7, 590, 331	0	59.00
60. 00   06000   LABORATORY	0. 000000	6, 767, 814	0	6, 297, 284	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	9, 957	0	7, 930, 889	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	1, 749, 535	0	842, 244	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	924, 087	0	165, 646	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	583, 237	0	49, 991	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	203, 157	0	18, 998	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	2, 392, 870	0	4, 414, 263	0	69.00
69. 01   06901   CARDI AC   REHAB	0. 000000	2, 960	0	906, 858	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	71, 208	0	1, 622, 832	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	3, 206, 984	0	6, 620, 961	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	6, 227, 718	0	38, 829, 531	0	73.00
73.01 07301 ULTRA SOUND	0. 000000	957, 600	0	2, 305, 217	0	73. 01
74.00 07400 RENAL DIALYSIS	0. 000000	175, 627	0	4, 238	0	74.00
76.00 03950 WOUND CARE	0. 000000	17, 492	0	2, 861, 347	0	76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	0. 000000	0	0	6, 001, 383	0	90.00
91. 00   09100   EMERGENCY	0. 005839	8, 215, 003	47, 967	15, 299, 473	89, 334	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	387, 351	0	456, 004	0	92.00
200.00   Total (lines 50 through 199)		52, 395, 500	47, 967	164, 323, 501	89, 334	200. 00

 
 Heal th Financial
 Systems
 HENDRICKS REGIONAL HEALTH

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provider
 Provi der CCN: 15-0005 Title XVIII

			litle	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	,	Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3.00	4. 00	5. 00	
-	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 260279	14, 019, 579	0	0	3, 649, 002	50.00
	D5001 ENDOSCOPY	0. 235558				1, 170, 343	1
	D5100 RECOVERY ROOM	0. 298978		1		1, 260, 152	
	D5200 DELIVERY ROOM & LABOR ROOM	0. 324529		_	_	1, 200, 132	1
	05300 ANESTHESI OLOGY	0. 324324		1	_	455, 793	
					_		
	D5400 RADI OLOGY-DI AGNOSTI C	0. 152219			_	2, 732, 068	
	D5401 RADI ATI ON-ONCOLOGY	0. 081307			_	1, 102, 440	
	D5600 RADI OI SOTOPE	0. 000000				0	
	D5601 NUCLEAR MEDICINE	0. 099804			_	260, 818	
	05900 CARDI AC CATHETERI ZATI ON	0. 101059			0	767, 071	59.00
60.00	06000 LABORATORY	0. 166062		0	0	1, 045, 740	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 100530	7, 930, 889	0	0	797, 292	64.00
65.00	06500 RESPI RATORY THERAPY	0. 457830	842, 244	0	0	385, 605	65.00
66.00	06600 PHYSI CAL THERAPY	0. 572285	165, 646	0	0	94, 797	66.00
	06700 OCCUPATI ONAL THERAPY	0. 389311	49, 991		0	19, 462	1
	06800 SPEECH PATHOLOGY	0. 357679		1	0	6, 795	
	06900 ELECTROCARDI OLOGY	0. 102070		1		450, 564	1
	06901 CARDI AC REHAB	0. 659745		1	n	598, 295	
	07000 ELECTROENCEPHALOGRAPHY	0. 253968			0	412, 147	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000		_	_	112, 147	1
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 487438				3, 227, 308	
	07300 DRUGS CHARGED TO PATTENTS						
		0. 277665			34, 024	10, 781, 602	
	07301 ULTRA SOUND	0. 108075			0	2.77.00	
	07400 RENAL DIALYSIS	0. 762435			_	3, 231	
	03950 WOUND CARE	0. 350296				1, 002, 318	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0. 155306		0	0	932, 051	90.00
91.00	09100 EMERGENCY	0. 135994	15, 299, 473	0	0	2, 080, 637	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 146068	456, 004	0	0	522, 612	92.00
200.00	Subtotal (see instructions)		164, 323, 501		34, 024		
201.00	Less PBP Clinic Lab. Services-Program			0	0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	1	164, 323, 501	0	34, 024	34, 007, 279	202.00
_52.50	, 2 goo ( 200 201)	ı	1 .0.,020,001	'	0.,021	0.1,00.1,217	

Health Financial Systems	HENDRICKS REGION	AL HEALTH	In Lieu of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0005	Period: Worksheet D From 01/01/2022 Part V
			To 12/21/2022 Data/Time Dropared

				To 12/31/2022		epared:
					5/31/2023 12:	20 pm
			XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLULARY OFRIVERS COOT OFFITERS	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS		_	I			
50. 00   05000   OPERATI NG ROOM	0	· -				50.00
50. 01   05001   ENDOSCOPY	0					50. 01
51.00   05100   RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00   05300   ANESTHESI OLOGY	0	0				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01   05401   RADI ATI ON-ONCOLOGY	0	0				54. 01
56. 00   05600   RADI 01 SOTOPE	0	0				56.00
56. 01   05601 NUCLEAR MEDICINE	0	0				56. 01
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0				59.00
60. 00   06000   LABORATORY	0	0				60.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00   06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01   06901   CARDI AC   REHAB	0	l o				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	9, 447				73. 00
73. 01   07301   ULTRA SOUND	0	0				73. 01
74. 00 07400 RENAL DI ALYSI S	0	0				74.00
76. 00 03950 WOUND CARE	0	,				76.00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0					77.00
OUTPATIENT SERVICE COST CENTERS						1 / / . 00
90. 00 09000 CLINIC	0	0				90.00
91. 00   09100  EMERGENCY			•			91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)						92.00
200.00 Subtotal (see instructions)		9, 447				200.00
		9, 447				200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges						201.00
202.00 Net Charges (line 200 - line 201)	0	9, 447				202. 00
202.00   Net charges (Title 200 - Title 201)	1	7, 447	I			1202.00

	Financial Systems HENDRICKS REGION			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0005	Peri od: From 01/01/2022	Worksheet D-1	
			To 12/31/2022		
		Title XVIII	Hospi tal	5/31/2023 12: PPS	20 pm
	Cost Center Description	Title XVIII	nospi tai	113	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			23, 169	
2.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed days)		rivete reem days	23, 169 0	
3. 00	do not complete this line.	lys). If you have only p	rivate room days,	U	3.00
1. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		18, 840	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		
	reporting period				
5. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through Decembe	r 31 of the cost	0	7.0
3. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8.0
. 00	reporting period (if calendar year, enter 0 on this line)	iii days) arter becember	51 01 the cost	O	0. 0
. 00	Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	5, 810	9.0
	newborn days) (see instructions)				
0.00	Swing-bed SNF type inpatient days applicable to title XVIII o	0	10.0		
11 00	through December 31 of the cost reporting period (see instruc			0	11 0
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e	0	11.0		
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.0
. 2. 00	through December 31 of the cost reporting period	wenty (merauring priva	to room dayo,	· ·	
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13.0
	after December 31 of the cost reporting period (if calendar $y$				
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	
6. 00	Nursery days (title V or XLX only) SWLNG BED ADJUSTMENT			0	16. C
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	17. C
7.00	reporting period	ics through becomber or	or the cost	0.00	'''
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.0
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	0. 00	19.0
	reporting period	6. 5			
0. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0. 00	20.0
1. 00	reporting period  Total general inpatient routine service cost (see instruction	ie)		36, 801, 924	21.0
	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		1
	5 x line 17)		ting pointed (initial		
3.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line d	0	23.0
	x line 18)	·			
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	0	24.0
	7 x line 19)				
- 00	Control to the control to the transfer of the control of the contr				
25. 00	Swing-bed cost applicable to NF type services after December $x$ line 20)	31 of the cost reportin	g period (line 8	0	25.0

	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	23, 169	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	23, 169	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	18, 840	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period	0	, 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	0	7. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	U	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	U	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	5, 810	9. 00
7. 00	newborn days) (see instructions)	0,010	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
44.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		44.00
	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	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 services through December 31 of the cost	0.00	17. 00
17.00	reporting period	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	reporting period	0.00	
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		
21. 00	Total general inpatient routine service cost (see instructions)	36, 801, 924	
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
24.00	X   line 18)	0	24.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line $ 7 \times  $ 1 ine 19)	U	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
23.00	x line 20)	O	23.00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	36, 801, 924	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Private 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
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	
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	36, 801, 924	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 500 41	20.00
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 588. 41	
39.00	Program general inpatient routine service cost (line 9 x line 38)	9, 228, 662 0	39. 00 40. 00
40. 00 41. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)  Total Program general inpatient routine service cost (line 39 + line 40)	9, 228, 662	
71.00	Trees Trogram general impatrion routine service cost (Title 37 + Title 40)	7, 220, 002	71.00

	Financial Systems ATION OF INPATIENT OPERATING COST	HENDRI CKS REGI			eri od:	u of Form CMS-2 Worksheet D-1	
				Т	rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/31/2023 12:	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospi tal Program Days	PPS Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00 0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	8, 051, 813	2, 693	2, 989. 90	841	2, 514, 506	43.00
44. 00 45. 00 46. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0, 031, 013	2,073	2, 909. 90	041	2, 314, 300	44. 00 45. 00 46. 00 47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	B, line 200)			11, 821, 830	48. 00
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				column 1)	0 23, 564, 998	
50. 00	Pass through costs applicable to Program inp III)	atient routine	services (fro	m Wkst. D, sum	of Parts I and	1, 348, 679	50.00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	844, 823	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines	,	مام معم مام	voi ai an anaath	atiot and	2, 193, 502	
53.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		erated, non-pri	ysician anestn	etist, and	21, 371, 496	53.00
54.00	Program di scharges					0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
55. 02	Adjustment amount per discharge (contractor					0.00	1
56.00	Target amount (line 54 x sum of lines 55, 55			li F/i	1: 52)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (	line 56 minus	iine 53)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost rep	orting period	ending 1996,	0.00	
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 $\div$ line 54,	or line 55 fro	om prior year	cost report, u	pdated by the	0. 00	60.00
61. 00	market basket) Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of t	the amount by	which operatin	g costs (line	0	61.00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62.00
	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after Decemb	per 31 of the	cost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVII	l only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31	of the cost re	porting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [	December 31 of	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III – SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	ity/ICF/IID rou	utine service	cost (line 37)			70.00 71.00
72. 00	Program routine service cost (line 9 x line	71)		ŕ			72.00
73.00	Medically necessary private room cost applic	5	•	,			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		•	art II, column		74.00 75.00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		arovi don nocen	de)			78. 00 79. 00
80.00	Total Program routine service costs for comp				us line 79)		80.00
81. 00	Inpatient routine service cost per diem limi				,		81.00
82.00	Inpatient routine service cost limitation (I		*				82.00
83.00	Reasonable inpatient routine service costs (		ns)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86.00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					4 000	07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	· line 2)			4, 329 1, 588. 41	1

Health Financial Systems	HENDRI CKS REG	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0005		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		pared: 20 pm_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (	see instructions	)			6, 876, 227	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	4, 633, 142	36, 801, 924	0. 12589	6, 876, 227	865, 676	90.00
91.00 Nursing Program cost	0	36, 801, 924	0. 00000	00 6, 876, 227	0	91.00
92.00 Allied health cost	0	36, 801, 924	0. 00000	00 6, 876, 227	0	92.00
93.00 All other Medical Education	0	36, 801, 924	0. 00000	00 6, 876, 227	0	93.00

Hoal th	ı Financial Systems HENDRICKS REG	IONAL HEALTH	In Lio	u of Form CMS-2	) 552 10
	TATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0005	Peri od:	Worksheet D-1	
001111 01	THIS OF THE THE STERVITTING GOOT	11011461 0011. 10 0000	From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/31/2023 12:	
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed	days, excluding newborn)		23, 169	1.00
2.00	Inpatient days (including private room days, excluding swi	ng-bed and newborn days)		23, 169	2.00
3. 00	Private room days (excluding swing-bed and observation bed do not complete this line.	l days). If you have only p	rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation	n bed days)		18, 840	4.00
5. 00	Total swing-bed SNF type inpatient days (including private reporting period	room days) through Decemb	er 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	room days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private reporting period	room days) through Decembe	r 31 of the cost	0	7. 00

	South Senter Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	23, 169	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	23, 169	
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation bed days)	18, 840	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	18, 840	5.00
3.00	reporting period	O	3.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
	reporting period		l
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	480	9.00
10.00	newborn days) (see instructions)	0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		ĺ
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		1
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
15.00	Total nursery days (title V or XIX only)	1, 906	1
16. 00	Nursery days (title V or XIX only)	142	16.00
17 00	SWING BED ADJUSTMENT  Medicago rate for awing had SNE comitions applicable to comitions through December 31 of the cost	0.00	17 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17.00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18.00
10.00	reporting period	0.00	10.00
19. 00	Medicald 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		l
21. 00	Total general inpatient routine service cost (see instructions)	36, 801, 924	
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
24. 00	X line 18)	0	24.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line   7 x line 19)	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
20.00	In line 20)	O	20.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	36, 801, 924	27.00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00	Private room charges (excluding swing-bed charges)	0	
30.00		0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	1
34. 00 35. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)	0. 00 0. 00	1
36.00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		1
57.00	27 minus line 36)	33, 301, 724	57.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 588. 41	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	762, 437	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)	762, 437	41.00

OMPUTATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2022	Worksheet D-1	
				To 12/31/2022	Date/Time Pre 5/31/2023 12:	
		Ti tl	e XIX	Hospi tal	Cost	20 piii
Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
	Cost	Days	÷ col . 2)	4.00	col . 4)	
2.00 NURSERY (title V & XIX only)	1. 00 2, 985, 838	2. 00 1, 906	3. 00 1, 566. 55	4. 00	5. 00 222, 450	42.0
Intensive Care Type Inpatient Hospital Unit 3.00 INTENSIVE CARE UNIT		2 (02	2, 989. 90	) 0	0	1 42 6
3.00   INTENSIVE CARE UNIT 4.00   CORONARY CARE UNIT	8, 051, 813	2, 693	2, 989. 90	) 0	Ü	43. C
5.00 BURN INTENSIVE CARE UNIT						45. C
6.00 SURGICAL INTENSIVE CARE UNIT 7.00 OTHER SPECIAL CARE (SPECIFY)						46. C
Cost Center Description					1.00	17.0
8.00 Program inpatient ancillary service cost (W	/kst. D-3, col. 3	3, line 200)			1. 00 810, 196	48.0
8.01 Program inpatient cellular therapy acquisit	ion cost (Worksh	neet D-6, Part		column 1)	0	
9.00 Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	s 41 through 48.0	01)(see instru	ctions)		1, 795, 083	49.0
0.00 Pass through costs applicable to Program in	patient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.0
	nationt ancillar	sy sorvices (f	com Wkst D s	um of Darte II	0	51.0
and IV)	ipati ent anci i a	y services (ii	OIII WKSt. D, S	um of Farts II	0	31.0
2.00 Total Program excludable cost (sum of lines		alatad === ='	vol ol on on a	otict on-	0	
3.00 Total Program inpatient operating cost excl medical education costs (line 49 minus line		erated, non-pn	ysician anestr	etist, and	0	53.0
TARGET AMOUNT AND LIMIT COMPUTATION	,					]
4.00 Program discharges 5.00 Target amount per discharge						54. 0 55. 0
5.01 Permanent adjustment amount per discharge					0.00	55.0
5.02 Adjustment amount per discharge (contractor						55. C
6.00 Target amount (line 54 x sum of lines 55, 57.00 Difference between adjusted inpatient opera			ine 56 minus	line 53)	0	1
8.00 Bonus payment (see instructions)	· ·			,	0	
9.00 Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket		n the cost rep	orting period	endi ng 1996,	0.00	59. (
0.00 Expected costs (lesser of line 53 ÷ line 54		om prior year	cost report, ι	pdated by the	0.00	60.0
market basket) 1.00   Continuous improvement bonus payment (if li	ne 53 ÷ line 54	is less than	the lowest of	lines 55 nlus	0	61.0
55.01, or line 59, or line 60, enter the le	esser of 50% of t	the amount by v	which operatir	g costs (line	, and the second	"
53) are less than expected costs (lines 54 enter zero. (see instructions)	x 60), or 1 % of	the target a	mount (line 56	), otherwise		
2.00 Relief payment (see instructions)						62.0
3.00 Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	uctions)			0	63.0
4.00 Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64.0
instructions)(title XVIII only)	osts after Decemb	or 21 of the	act reporting	pariod (Saa		45.0
5.00 Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	ists after Decemb	ber 31 of the c	cost reporting	perroa (see	0	65.0
6.00 Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVII	I only); for	0	66.0
CAH, see instructions 7.00 Title V or XIX swing-bed NF inpatient routi	ne costs through	n December 31 (	of the cost re	porting period	0	67.0
(line 12 x line 19)						,,,
8.00 Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs arter L	becember 31 Of	the cost repo	n ung perioa	0	68.0
9.00 Total title V or XIX swing-bed NF inpatient					0	69.0
PART III - SKILLED NURSING FACILITY, OTHER  0.00 Skilled nursing facility/other nursing faci						70.0
1.00 Adjusted general inpatient routine service	cost per diem (I		, ,			71.0
2.00 Program routine service cost (line 9 x line 3.00 Medically necessary private room cost appli		n (line 14 v li	ne 35)			72.0
4.00   Total Program general inpatient routine ser						74. 0
5.00 Capital-related cost allocated to inpatient	routine service	e costs (from \	Worksheet B, F	art II, column		75.0
26, line 45) 6.00   Per diem capital-related costs (line 75 ÷ l	ine 2)					76.0
7.00 Program capital-related costs (line 9 x lir	ne 76)					77.0
8.00 Inpatient routine service cost (line 74 mir 9.00 Aggregate charges to beneficiaries for exceptions)		provi den irecon	ds)			78. 0 79. 0
0.00 Total Program routine service costs for com				us line 79)		80.0
1.00 Inpatient routine service cost per diem lim		1)				81.0
2.00 Inpatient routine service cost limitation (3.00 Reasonable inpatient routine service costs						82.0
4.00 Program inpatient ancillary services (see i	nstructions)					84.0
5.00 Utilization review - physician compensation 6.00 Total Program inpatient operating costs (su						85. C
PART IV - COMPUTATION OF OBSERVATION BED PA		n ought oo)				30.0
					4, 329	

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/31/2023 12:	pared: 20 pm_
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			6, 876, 227	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	4, 633, 142	36, 801, 924	0. 12589	6, 876, 227	865, 676	90.00
91.00 Nursing Program cost	0	36, 801, 924	0. 00000	00 6, 876, 227	0	91.00
92.00 Allied health cost	0	36, 801, 924	0. 00000	00 6, 876, 227	0	92.00
93.00 All other Medical Education	0	36, 801, 924	0. 00000	00 6, 876, 227	0	93.00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (	CCN: 15-0005	Period: From 01/01/2022	Worksheet D-3	3
				To 12/31/2022		
		Ti tl	e XVIII	Hospi tal	PPS	20 μιι
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges		Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS			12, 735, 880		30.00
31. 00	03100 I NTENSI VE CARE UNI T			2, 634, 627		31.00
43. 00	04300 NURSERY			2,001,027		43.00
	ANCILLARY SERVICE COST CENTERS					1
50.00	05000 OPERATING ROOM		0. 2602	79 6, 705, 385	1, 745, 271	50.00
50. 01	05001 ENDOSCOPY		0. 2355	58 435, 023	102, 473	50.01
51.00	05100 RECOVERY ROOM		0. 2989	78 956, 317	285, 918	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 3245	29 C	0	52.00
53.00	05300 ANESTHESI OLOGY		0. 0953			
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1522			
54. 01	05401 RADI ATI ON-ONCOLOGY		0. 0813		· ·	
56. 00	05600 RADI 0I SOTOPE		0.0000			
56. 01	05601 NUCLEAR MEDICINE		0. 0998	· ·	· ·	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 1010			
50.00	06000 LABORATORY		0. 1660			
54.00	06400 I NTRAVENOUS THERAPY		0. 1005			
55.00	06500 RESPI RATORY THERAPY		0. 4578			
66.00	06600 PHYSI CAL THERAPY		0. 5722			
57.00	06700 OCCUPATI ONAL THERAPY		0. 3893			
58. 00 59. 00	O6800   SPEECH   PATHOLOGY   O6900   ELECTROCARDI OLOGY		0. 3576	·	· ·	
59. 00 59. 01	06901 CARDI AC REHAB		0. 1020 0. 6597			
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 0597	·		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2534			
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 4874		_	1
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 2776			
73. 00	07301 ULTRA SOUND		0. 1080			
74. 00	07400 RENAL DI ALYSI S		0. 7624			
76. 00	03950 WOUND CARE		0. 3502	·		
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION		0.0000			
	OUTPATIENT SERVICE COST CENTERS		0.0000	00,		1 /// 5
90.00	09000 CLI NI C		0. 1553	06 C	0	90.00
	09100 EMERGENCY		0. 1359			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 1460			
200. 00				52, 395, 500		
201. 00		ges (line 61)		C		201.0
202. 00		- '		52, 395, 500		202. 0

The Part Ent Anciclary Service COST APPORTIONMENT	Health Financial Systems HENDRICKS REGIONAL HEA	AT IZ		In lie	u of Form CMS-:	2552_10
Title XIX   Start			CN: 15-0005			
NAME   Cost	THE PROPERTY OF SERVICE SERVICES SERVIC	. 40. 0	10 0000	From 01/01/2022		
NATION   Cost   Center Description   Ratio of Cost   Inpatient To Charges   Program Program Costs (col. 1 x col. 2)   1.00   2.00   3.00   1.00   3						
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3		Ti tl				
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3	Cost Center Description					
IMPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00			To Charges	-		
IMPATI ENT ROUTI NE SERVICE COST CENTERS				Charges		
IMPATIENT ROUTINE SERVICE COST CENTERS   30.00   30.00   30.00   ADULTS & PEDIATRIC S.   390, 627   31.00   43.00   31.00			1 00	2 00		
30.00	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
31. 00   03100   INTENSIVE CARE UNIT   390, 621   31. 00   43. 0				2 531 358		30.00
A3.00   04300   NURSERY   A0.00   A0						1
ANCIL LARY SERVICE COST CENTERS   Service   COST CENTERS   Service   COST CENTERS   Service				· ·		1
50.00						1
SO. 01   OSOOT   ENDOSCOPY   0. 235558   40, 496   9, 539   50. 01			0. 2602	79 400, 823	104, 326	50.00
52.00   05200   DELI VERY ROOM & LABOR ROOM   0.324529   0   0   52.00	50. 01   05001   ENDOSCOPY				9, 539	50. 01
53.00   05300   ANESTHESI OLOGY   0.095302   125, 475   11, 958   53.00   54.00   05400   RADI OLOGY-DI AGNOSTI C   0.152219   254, 023   38, 667   54.00   54.01   RADI ATI ON-ONCOLOGY   0.081307   1, 628   132   54.01   54.01   05401   RADI ATI ON-ONCOLOGY   0.081307   1, 628   132   54.01   55.00   05600   RADI OLOGY   0.000000   0   0   0   0.081307   1, 628   132   54.01   05601   NUCLEAR MEDI CI NE   0.099804   17, 801   1,777   56.01   05601   NUCLEAR MEDI CI NE   0.099804   17, 801   1,777   56.01   05900   CARDI AC CATHETERI ZATI ON   0.101059   516, 665   52, 214   59.00   06900   CARDI AC CATHETERI ZATI ON   0.100530   0.060000   0.060000   0.060000   0.0600000   0.06000000   0.060000000   0.060000000000	51.00   05100   RECOVERY ROOM		0. 2989	78 39, 222	11, 727	51.00
54. 00   05400   RADI OLOGY_DI AGNOSTI C   0.152219   254, 0.23   38, 667   54. 00   05401   RADI ATI ON-ONCOLOGY   0.081307   1.628   132   54. 01   55. 00   05600   RADI OI SOTOPE   0.000000   0   0.56. 00   05600   RADI OI SOTOPE   0.000000   0   0.56. 00   056. 00   05600   CARDI ACC ATHETERI ZATI ON   0.001059   516, 665   52, 214   59. 00   05900   CARDI ACC ATHETERI ZATI ON   0.100530   0   0.6000   0.00000   0.000000   0.0000000   0.00000000	52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 32452	29 0	0	52.00
54.01   05401   RADI ATI ON-ONCOLOGY   0.081307   1,628   132   54.01     56.00   05600   RADI OI SOTOPE   0.000000   0   0.56.00     56.01   05601   NUCLEAR MEDI CINE   0.099804   17,801   1,777   56.01     59.00   05900   CARDI AC CATHETERI ZATI ON   0.101059   516,665   52,214   59.00     60.00   06400   LABORATORY   0.100530   0   0.64.00     64.00   06400   INTRAVENOUS THERAPY   0.100530   0   0.64.00     65.00   06500   RESPI RATORY THERAPY   0.457830   204,334   93,550   65.00     67.00   06600   CLUPATI ONAL THERAPY   0.572285   57,910   33,141   66.00     67.00   06700   0CCUPATI ONAL THERAPY   0.389311   33,391   12,999   67.00     68.00   06800   SPECH PATHOLOGY   0.387679   21,290   7,615   68.00     69.00   06900   ELECTROCARDI OLOGY   0.102070   142,955   14,591   69.00     69.01   06901   CARDI AC REHAB   0.659745   948   625   69.01     70.00   07000   ELECTROENCEPHALOGRAPHY   0.253968   2,280   579   70.00     71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.263968   2,280   579   70.00     72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   0.277665   680,924   189,069   73.00     73.01   07301   UITRA SOUND   0.108075   113,194   12,233   73.01     74.00   07400   RENAL DI ALYSIS   0.155306   0.000000   0.000000   0.000000     77.00   07700   ALLOGENEIC STEM CELL ACQUI SI TI ON   0.000000   0.000000   0.000000   0.0000000     77.00   07700   CLINIC   0.0000000   0.000000   0.0000000   0.0000000   0.00000000			0. 09530	125, 475	11, 958	53.00
56. 00   05600   RADI OI SOTOPE   0.000000   0   0   56. 00	54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 1522	19 254, 023	38, 667	54.00
56. 01   05601   NUCLEAR MEDICINE   0. 099804   17, 801   1,777   56. 01						
59. 00   05900   CARDIAC CATHETERIZATION   0. 101059   516, 665   52, 214   59. 00   60. 00   06000   LABORATORY   0. 166062   652, 583   108, 369   60. 00   64. 00   0640   INTRAVENOUS THERAPY   0. 100530   0   0   64. 00   0640   INTRAVENOUS THERAPY   0. 100530   0   0   64. 00   06500   RESPIRATORY THERAPY   0. 457830   204, 334   93, 550   65. 00   06600   PHYSI CAL THERAPY   0. 572285   57, 910   33, 141   66. 00   06600   PHYSI CAL THERAPY   0. 372285   57, 910   33, 141   66. 00   06600   PHYSI CAL THERAPY   0. 389311   33, 391   12, 999   67. 00   06900   ELECTROCARDI OLOGY   0. 357679   21, 290   7. 615   68. 00   06900   ELECTROCARDI OLOGY   0. 102070   142, 955   14, 591   69. 00   06900   ELECTROCARDI OLOGY   0. 102070   142, 955   14, 591   69. 00   06901   CARDI AC REHAB   0. 659745   948   625   69. 01   06901   CARDI AC REHAB   0. 253968   2, 280   579   70. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 000000   0   0   71. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 000000   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 277665   680, 924   189, 069   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 108075   113, 194   12, 233   73. 01   74. 00   07400   RENAL DI ALYSI S   0. 762435   14, 305   10, 907   74. 00   07400   RENAL DI ALYSI S   0. 762435   14, 305   10, 907   74. 00   07700   ALLOGENEIC STEM CELL ACQUI SITION   0. 000000   0   0   0   0   0   0   0						
60. 00   06000   LABORATORY   0. 166062   652, 583   108, 369   60. 00   64. 00   6400   INTRAVENOUS THERAPY   0. 100530   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   0. 572285   57, 910   33, 141   66. 00   66. 00   06700   0CCUPATI ONAL THERAPY   0. 389311   33, 391   12, 999   67. 00   06700   0CCUPATI ONAL THERAPY   0. 357679   21, 290   7, 615   68. 00   06900   ELECTROCARDI OLOGY   0. 102070   142, 955   14, 591   69. 00   06900   ELECTROCARDI OLOGY   0. 102070   142, 955   14, 591   69. 00   06901   CARDI AC REHAB   0. 659745   948   625   69. 01   07000   ELECTROENCEPHALOGRAPHY   0. 253968   2, 280   579   70. 00   07100   MEDIC CAL SUPPLIES CHARGED TO PATIENTS   0. 487438   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 487438   0   0   72. 00   07300   DRUGS CHARGED TO PATIENTS   0. 487438   0   0   72. 00   07300   DRUGS CHARGED TO PATIENTS   0. 487438   0   0   72. 00   07300   DRUGS CHARGED TO PATIENTS   0. 277665   680, 924   189, 069   73. 01   7301   ULTRA SOUND   0. 108075   113, 194   12, 233   73. 01   7301   ULTRA SOUND   0. 108075   113, 194   12, 233   73. 01   7301   ULTRA SOUND   0. 108075   113, 194   12, 233   73. 01   7500   07400   RENAL DI ALYSIS   0. 350296   0   0   76. 00   0   77. 00   00000   0   0   0   0   0   0   0			1	· ·		
64. 00   06400   INTRAVENOUS THERAPY   0.100530   0   0   64. 00   65. 00   06500   RESPIRATORY THERAPY   0.457830   204, 334   93, 550   65. 00   06600   PMSPI CAL THERAPY   0.572285   57, 910   33, 141   66. 00   067. 00   067. 00   000000   0000000   000000000   000000			1			1
65. 00			1	· ·		
66. 00 06600 PHYSICAL THERAPY 0. 572285 57, 910 33, 141 66. 00 67. 00 06700 0CCUPATIONAL THERAPY 0. 389311 33, 391 12, 999 67. 00 680. 0 680. 0 680. SPEECH PATHOLOGY 0. 357679 21, 290 7, 615 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 102070 142, 955 14, 591 69. 00 69. 01 06901 CARDI AC REHAB 0. 659745 948 625 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 253968 2, 280 579 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 0487438 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 277665 680, 924 189, 069 73. 00 73. 01 ULTRA SOUND 0. 108075 113, 194 12, 233 73. 01 07301 ULTRA SOUND 0. 108075 113, 194 12, 233 73. 01 74. 00 07400 RENAL DI ALYSI S 0. 365096 0 0 76. 00 07500 ALLOGENEIC STEM CELL ACQUISITION 0. 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
67. 00						1
68. 00						
69. 00   06900   CARDI AC REHAB   0. 102070   142, 955   14, 591   69. 00   69. 01   06901   CARDI AC REHAB   0. 659745   948   625   69. 01   69. 01   69. 00   69. 01   69. 00   69.			1	· ·		
69. 01 06901 CARDI AC REHAB  70. 00 07000 ELECTROENCEPHALOGRAPHY  70. 00 07000 ELECTROENCEPHALOGRAPHY  70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS  70. 00 07200 IMPL. DEV. CHARGED TO PATIENTS  70. 00 07300 DRUGS CHARGED TO PATIENT  70. 00 07300 DRUGS CHARGED TO PATIENTS  70. 00 07300 DRUGS CHARGED TO PATIENTS  70. 00 07300 DRUGS CHARGED TO PATIENTS  70. 00 07400 RENAL DI ALYSIS  70. 00 07400 RENAL DI ALYSIS  70. 00 07400 ALLOGENEIC STEM CELL ACQUISITION  70. 00 07700 ALLOGENEIC STEM CELL ACQUISITION  70. 00 09000 CLI NI C  70. 00 09000 CLI NI C  70. 00 09000 D9000 D900						1
70.00						
71. 00						1
72. 00			1	· ·		
73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 277665   680, 924   189, 069   73. 00   73. 01   07301   ULTRA SOUND   0. 108075   113, 194   12, 233   73. 01   74. 00   07400   RENAL DI ALYSIS   0. 762435   14, 305   10, 907   74. 00   76. 00   07500   ALLOGENEIC STEM CELL ACQUISITION   0. 000000   0   0   0   0   0   0   0			1			
73. 01 07301 ULTRA SOUND 0.108075 113, 194 12, 233 73. 01 74. 00 07400 RENAL DI ALYSI S 0.762435 14, 305 10, 907 74. 00 76. 00 03950 WOUND CARE 0.350296 0 0 0 76. 00 0770 ALLOGENEI C STEM CELL ACQUISITION 0.000000 0 0 0 77. 00  OUTPATIENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0.155306 0 0 90. 00 91. 00 09100 EMERGENCY 0.135994 707, 219 96, 178 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 1.146068 0 0 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00			1			
74. 00 07400 RENAL DI ALYSIS 10, 907 74. 00 76. 00 03950 WOUND CARE 0. 350296 0 0 0 76. 00 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 000000 0 0 0 77. 00  OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLI NI C 0. 155306 0 0 90. 00 91. 00 09100 EMERGENCY 0. 135994 707, 219 96, 178 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 1. 146068 0 0 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 4, 027, 466 810, 196 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00			1			1
76. 00						1
OUTPATIENT SERVICE COST CENTERS   O	76. 00 03950 WOUND CARE		0. 35029	96 0	0	76.00
90. 00   09000   CLINIC   0. 155306   0   90. 00   91. 00   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   1. 146068   0   92. 00   201. 00   09200	77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0. 00000	00	0	77. 00
91. 00   09100   EMERGENCY   0. 135994   707, 219   96, 178   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   1. 146068   0   92. 00   201. 00   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   201. 00   201. 00   0. 135994   1. 146068   0   0   92. 00   92. 00   00   00   00   00   00   00   00	OUTPATIENT SERVICE COST CENTERS					
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   1. 146068   0   92. 00   200. 00   201. 00   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   201. 00   201. 00   201. 00   0   0   0   0   0   0   0   0   0						
200.00 Total (sum of lines 50 through 94 and 96 through 98) 4,027,466 810,196 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00			1			
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00			1. 1460		_	
				4, 027, 466	810, 196	1
202.00   Net charges (line 200 minus line 201)   4,027,466     202.00		ie 61)		0		1
	202.00   Net charges (line 200 minus line 201)		I	4, 027, 466		202.00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Li eu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/31/2023 12:20 pm

	Title XVII	11	Hospi tal	5/31/2023 12: PPS	20 pm
		<u>'</u>		1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to Octo	ober 1 (s	see	0 12, 191, 344	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after (instructions)	October 1	l (see	4, 307, 547	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges oci 1 (see instructions)	curring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occoctober 1 (see instructions)	curring o	on or after	0	1.04
2. 00	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.00
2. 02 2. 03 2. 04	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)			0 224, 469 19, 303	2. 02 2. 03 2. 04
3. 00 4. 00	Managed Care Simulated Payments  Bed days available divided by number of days in the cost reporting period (see	,	rtions)	19, 303 0 117. 95	3. 00 4. 00
	Indirect Medical Education Adjustment				
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost report before 12/31/1996. (see instructions)				5.00
5. 01 6. 00	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see in: FTE count for allopathic and osteopathic programs that meet the criteria for new programs in accordance with 42 CFR 413.79(e)			0.00	5. 01 6. 00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building winds the CAA 2021 (see instructions)	low closed	d under §127 of	0. 00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412. ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412. 105 cost report straddles July 1, 2011 then see instructions.			0. 00 0. 00	7. 00 7. 01
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE I track programs with a rural track for Medicare GME affiliated programs in account 87 FR 49075 (August 10, 2022) (see instructions)		` ′	0. 00	7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopa affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 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 under § 5503 report straddles July 1, 2011, see instructions.	of the A	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closer under § 5506 of ACA. (see instructions)	ed teachir	ng hospital	0. 00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under $\$126\ o$ instructions)			0. 00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus line minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	tions)		0.00	9.00
10. 00 11. 00		our record	IS		11.00
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.				12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or a otherwise enter zero.	ıfter Sept	tember 30, 1997,	0. 00	14. 00
	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program (see instructions)				15. 00 16. 00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count			0. 00 0. 00	17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	
	Prior year resident to bed ratio (see instructions)			0.000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)  IME payment adjustment (see instructions)			0.000000	•
22. 01	IME payment adjustment - Managed Care (see instructions)			0	
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots unit	nder 42 CF	FR 412. 105	0.00	23. 00
24. 00	(f)(1)(iv)(C).  IME FTE Resident Count Over Cap (see instructions)	!!	24 /	0.00	
25. 00	instructions)	or rine	24 (See	0.00	
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4)  IME payments adjustment factor. (see instructions)			0. 000000 0. 000000	
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 29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 00 29. 01
	<u>Disproportionate Share Adjustment</u> Percentage of SSI recipient patient days to Medicare Part A patient days (see	instruct	tions)	1. 18	
31.00					31.00
	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			22. 06 7 <i>4</i> 1	32. 00 33. 00
	The condition of the condition of the contract of the conditions			7.41	

Provider CDN: 15-000b   Period   Peri	Heal th	Financial Systems HENDRICKS REGION	NAI HFAITH	Inlie	u of Form CMS-2	2552-10
1.00   1.00				Peri od: From 01/01/2022	Worksheet E Part A Date/Time Pre	pared:
Mocorpoperationate share adjustment (see instructions)			Title XVIII	Hospi tal		20 pm
					1 00	
Discompensated Care Payment Adjustment	34. 00	Disproportionate share adjustment (see instructions)				34.00
					On/After 10/1	
		Uncomponented Care Downert Adjustment		1.00	2. 00	
Sacrage   Factor 3 (see instructions)   0.000000000   0.000000000   35.00   1.000000000   0.000000000   0.000000000   0.00000000	35. 00			0	0	35.00
See   Instructions    35.03   Por rate share of the hospital UCP, including supplemental UCP (see instructions)   1,669,105   524,136   35.03   2,213,241   30.00		,				
35 0.0   Pror tat share of the hospital UCP, including supplemental UCP (see Instructions)   1,689,105   524,136   35,03     Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)   40,00   1016   1580 Medicare discharges (see Instructions)   0   40,00   1016   1580 Medicare discharges (see Instructions)   0   41,00   41,00   1016   1580 Medicare discharges (see Instructions)   0   41,00	35. 02		, enter zero on this line	e) 2, 258, 328	2, 079, 450	35. 02
Additional payment for high percentage of ESRD beneficiary discharges (clines 40 through 46)   0	35. 03	1.	CP (see instructions)	1, 689, 105	524, 136	35. 03
40.00   Total   Medicare discharges (see instructions)   0   41.00   17.10   Total   ESR0   Medicare discharges (see instructions)   0   41.00   17.10   Total   ESR0   Medicare covered and paid discharges (see instructions)   0   41.00	36. 00					36.00
1.00   Total ESRD Modicare discharges (see Instructions)   0   0   0   0   0   0   0   0   0	40.00		ischarges (lines 40 thro	<u> </u>		10.00
1.01   Total ESRD Modicare covered and paid discharges (see instructions)		,				•
43.00   Total Medicare ESRD Inpatient days (see instructions)   0   43.00   44.00   44.00   45.00   46.00   70.01   45.00   46.00   70.01   45.00   46.00   70.01   45.00   46.00   70.01   45.00   46.00   70.01   45.00   46.00   70.01   45.00   46.00   70.01   45.00   46.00   70.01   45.00   46.00   70.01   46.00			tions)			1
44.00   Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7   0.000000   days)   45.00   Average weekly cost for dialysis treatments (see instructions)   0.00   46.00   70.00   46.00   70.00   46.00   70.00   46.00   70.00   80.00   70.00   80.00   70.00   80.00   70.00   80.00   70.00   80.00   70.00   80.00   70.00   80.00   70			ify for adjustment)	0.00		ł
days		1	by line 41 divided by 7	0 000000		ł
46.00   Total additional payment (line 45 times line 44 times line 41.01)   0   19,261,546   47.00   48.00   Hospital specific payments (to be completed by SCH and MDH, small rural hospitals on only. (see instructions)   19,261,546   47.00   48.00   100		days)	•			
A7.00   Subtotal (see instructions)   19, 261, 546   47.00   48.00   0   0   0   0   0   0   0   0   0		, ,	•	0.00		•
ABO   Hospital specific payments (to be completed by SCH and MDH, small rural hospitals   O   ABO   ABO			1.01)	19, 261, 546		1
Amount	48. 00		small rural hospitals	_		48. 00
1.00		only. (see instructions)			Amount	
50.00         Payment for inpatient program capital (from Wkst. L. Pt. I and Pt. II. as applicable)         1, 325, 823   50.00           51.00         Exception payment for inpatient program capital (Wkst. L. Pt. III. see instructions)         0 51.00           52.00         Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).         0 52.00           53.00         Nursing and Allied Healt th Managed Care payment         0 53.00           54.01         Special add-on payments for new technologies         55.90           54.01         Islet isolation add-on payment         0 55.00           55.00         Net organ acquisition cost (Wkst. D-4 Pt. III., col. 1, line 69)         0 55.00           55.01         Celful ar therapy acquisition cost (see instructions)         0 55.00           67.00         Routine service other pass through costs (from Wkst. D, Pt. III., col umn 9, lines 30 through 35).         0 55.00           58.00         Ancil Iarry service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)         47,967         58.00           69.00         Primary payer payments         20,690,844         60.00         20,690,844         60.00           60.00         Primary payer payments         20,690,844         60.00         11,946,960         62.00           60.00         All owable bad debts (see instructions)         35,153						
51.00   Exception payment for inpatient program capital (West. L. Pt. III, see instructions)   0   51.00   0   0   0   0   0   0   0   0   0		, , , , , , , , , , , , , , , , , , , ,	•			1
52.00         Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).         0         52.00           53.00         Nursing and Allied Health Managed Care payment         0         53.00           54.01         Special add-on payments for new technologies         55,906           54.01         Islet isolation add-on payment         0         54.01           55.00         Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)         0         55.01           55.01         Cellular therapy acquisition cost (see instructions)         0         55.01           57.00         Routine service other pass through costs (from Wkst. D, Pt. III, col umn 9, lines 30 through 35).         0         56.00           58.00         Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11 line 200)         47,967         58.00           59.00         Total (sum of amounts on lines 49 through 58)         20,691,242         59.00           61.00         Total anount payable for program beneficiaries (line 59 minus line 60)         20,690,844         61.00           62.00         Deductibles billed to program beneficiaries         11,946,960         62.00           63.00         Coinsurance billed to program beneficiaries         11,946,960         62.00           64.00         Allowable bad debts (see instructions)				)		1
53.00         Nursing and Allied Health Managed Care payment         0         53.00           54.01         Special add-on payments for new technologies         55.906         54.01           54.01         Islet isolation add-on payment         0         54.01           55.00         Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)         0         55.00           56.01         Cellular therapy acquisition cost (see instructions)         0         55.00           56.00         Routine service other pass through costs (from Wkst. D, Pt. III, col. umn 9, lines 30 through 35).         0         56.00           57.00         Routine service other pass through costs (from Wkst. D, Pt. IIV, col. 11 line 200)         47, 967         58.00           59.00         Total (sum of amounts on lines 49 through 58)         20, 691, 242         59.00           61.00         Total (sum of amounts on lines 49 through 58)         20, 691, 242         59.00           61.00         Total amount payable for program beneficiaries (line 59 minus line 60)         20, 690, 844         61.00           62.00         Deductible sbilled to program beneficiaries         11, 670         63.00           63.00         Coinsurance billed to program beneficiaries         11, 670         63.00           64.00         Allowable bad debts (see instructions)         35,						ł
54.01   Islet isolation add-on payment   0   54.01   15.00		1 3 1	, 555	'		•
55. 00       Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)       0       55. 00       Cellular therapy acquisition cost (see instructions)       0       55. 01         56. 00       Cost of physicians' services in a teaching hospital (see instructions)       0       55. 01         57. 00       Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).       0       57. 00         58. 00       Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)       47, 967       58. 00         59. 00       Total (sum of amounts on lines 49 through 58)       20, 691, 242       59. 00         60. 00       Primary payer payments       398       60. 00         61. 00       Total amount payable for program beneficiaries (line 59 minus line 60)       20, 690, 844       61. 00         62. 00       Deductibles billed to program beneficiaries       11, 670       62. 00       11, 670       63. 00         63. 00       Coinsurance billed to program beneficiaries       11, 670       63. 00       64. 00       Allowable bad debts (see instructions)       35, 133       65. 00         65. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       35, 153       65. 00         66. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       18, 767, 367		1.				1
55. 01   Cellular therapy acquisition cost (see instructions)   0   55. 01			(0)			
56.00 Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 62.00 Deductibles billed to program beneficiaries 63.00 Coinsurance billed to program beneficiaries 64.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 69.00 There ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI FV) 69.07 To STEAD TRANTS (SEE INSTRUCTIONS) (SPECI FV) 69.08 Pomonstration payment adjustment amount (see instructions) 70.75 NPS respirator payment adjustment amount (see instructions) 70.87 Demonstration payment adjustment amount (see instructions) 70.98 Pioneer ACO demonstration payment adjustment amount (see instructions) 70.99 HSP bonus payment HRR adjustment amount (see instructions) 70.99 HSP bonus payment HRR adjustment amount (see instructions) 70.99 HSP payment adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 To.99		1	07)			1
58.00       Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)       47, 967       58.00         59.00       Total (sum of amounts on lines 49 through 58)       20,691, 242       59.00         60.00       Primary payer payments       398       60.00         61.00       Total amount payable for program beneficiaries (line 59 minus line 60)       20,690,844       61.00         62.00       Deductibles billed to program beneficiaries       1,946,960       62.00         63.00       Coinsurance billed to program beneficiaries       11,670       63.00         64.00       Allowable bad debts (see instructions)       54,082       64.00         65.00       Adjusted reimbursable bad debts (see instructions)       35,153       65.00         66.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       35,153       65.00         67.00       Subtotal (line 61 plus line 65 minus lines 62 and 63)       4,142       66.00         68.00       Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)       18,767,367       67.00         69.00       Ottler payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)       0 69.00         70.50       Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)			ructions)			•
Total (sum of amounts on lines 49 through 58)  60.00 Primary payer payments  Total amount payable for program beneficiaries (line 59 minus line 60)  62.00 Deductibles billed to program beneficiaries  63.00 Coinsurance billed to program beneficiaries  64.00 Allowable bad debts (see instructions)  65.00 Adjusted reimbursable bad debts (see instructions)  66.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)  68.00 Ottel received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)  69.00 Ottler payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  70.75 Ottler ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  70.87 Demonstration payment adjustment amount (see instructions)  70.87 Demonstration payment adjustment amount (see instructions)  70.90 HSP bonus payment HRR adjustment amount (see instructions)  70.91 HSP bonus payment HRR adjustment amount (see instructions)  70.92 HRR adjustment amount (see instructions)  70.94 HRR adjustment amount (see instructions)  70.94 HRR adjustment amount (see instructions)  70.94 HRR adjustment amount (see instructions)  70.95 Otto Primary payment adjustment amount (see instructions)  70.96 Otto Primary payment adjustment amount (see instructions)  70.97 Otto Primary payment adjustment amount (see instructions)  70.99 Otto Primary payment adjustment amount (see instructions)  70.90 Otto Primary payment adjustment amount (see instructions)  70.91 Otto Primary payment adjustment amount (see instructions)  70.92 Otto Primary payment adjustment amount (see instructions)  70.93 Otto Primary payment payment adjustment amount (see instructions)  70.94 Otto Primary payment payment amount (see instructions)  70.94 Otto Primary payment payment payment amount (see instructions)  70.90 Otto Primary payment payment payment amount (see instructions)  70.91 Otto Primary payment payment payment amount (see instructions)  70.91 Otto Primary payment payment paym				through 35).		1
60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 62.00 Deductibles billed to program beneficiaries 63.00 Coinsurance billed to program beneficiaries 65.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 60.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 60.07 To. 50 Nos respirator payment adjustment amount (see instructions) 60.00 The payment adjustment amount (see instructions) 60.00 Th			IV, col. 11 line 200)			•
61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 62.00 Deductibles billed to program beneficiaries 63.00 Coinsurance billed to program beneficiaries 64.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 69.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions) 70.87 Demonstration payment adjustment amount (see instructions) 70.88 SCH or MDH volume decrease adjustment (contractor use only) 70.90 HSP bonus payment HVBP adjustment amount (see instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 70.92 HVBP payment adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.95						1
63.00   Coinsurance billed to program beneficiaries   11,670   63.00   64.00   Allowable bad debts (see instructions)   54,082   64.00   65.00   Adjusted reimbursable bad debts (see instructions)   35,153   65.00   66.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   4,142   66.00   67.00   Subtotal (line 61 plus line 65 minus lines 62 and 63)   18,767,367   67.00   68.00   Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)   0 68.00   00   Other ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   70.00   00   00   00   00   00		Total amount payable for program beneficiaries (line 59 minu	s line 60)			l .
64.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 69.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 69.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions) 70.75 N95 respirator payment adjustment amount (see instructions) 70.87 Demonstration payment adjustment amount before sequestration 70.88 SCH or MDH volume decrease adjustment (contractor use only) 70.89 Pioneer ACO demonstration payment adjustment amount (see instructions) 70.90 HSP bonus payment HRR adjustment amount (see instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 70.92 Bundled Model 1 discount amount (see instructions) 70.93 70.94 HRR adjustment amount (see instructions) 70.70.94						1
Adjusted reimbursable bad debts (see instructions)  66.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)  68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)  69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  69.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)  70.75 N95 respirator payment adjustment amount (see instructions)  70.87 SCH or MDH volume decrease adjustment (contractor use only)  70.89 Pioneer ACO demonstration payment adjustment amount (see instructions)  70.90 HSP bonus payment HVBP adjustment amount (see instructions)  80 TO.90  70.91 HSP bonus payment HRR adjustment amount (see instructions)  90 TO.92  70.93 HVBP payment adjustment amount (see instructions)  91 TO.94  10 TO.94  10 TO.95  10 TO.90  11 A, 142 66.00  4, 142 66.00  18, 767, 367  67.07  68.00  69.00  69.00  70.80  70.90  70.90  70.90  70.91  70.91  70.91  70.92		1 3			·	•
66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 69.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions) 70.75 N95 respirator payment adjustment amount (see instructions) 70.87 Demonstration payment adjustment amount before sequestration 70.88 SCH or MDH volume decrease adjustment (contractor use only) 70.90 HSP bonus payment HVBP adjustment amount (see instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 70.92 Bundled Model 1 discount amount (see instructions) 70.93 HVBP payment adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.94						1
68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions) 70.75 N95 respirator payment adjustment amount (see instructions) 70.87 Demonstration payment adjustment amount before sequestration 70.88 SCH or MDH volume decrease adjustment (contractor use only) 70.89 Pioneer ACO demonstration payment adjustment amount (see instructions) 70.90 HSP bonus payment HVBP adjustment amount (see instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 70.92 HVBP payment adjustment amount (see instructions) 70.93 HVBP payment adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.94		, , , , , , , , , , , , , , , , , , , ,	tructi ons)			
69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)  70.75 N95 respirator payment adjustment amount (see instructions)  70.87 Demonstration payment adjustment amount before sequestration  70.88 SCH or MDH volume decrease adjustment (contractor use only)  70.99 HSP bonus payment HVBP adjustment amount (see instructions)  70.90 HSP bonus payment HVBP adjustment amount (see instructions)  70.91 HSP bonus payment HRR adjustment amount (see instructions)  70.92 Bundled Model 1 discount amount (see instructions)  70.93 HVBP payment adjustment amount (see instructions)  70.94 HRR adjustment amount (see instructions)  70.95 O 70.99  70.91 HRR adjustment amount (see instructions)  70.92 O 70.93		,	A STATE OF THE PROPERTY OF			•
70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)  70.75 N95 respirator payment adjustment amount (see instructions)  70.87 Demonstration payment adjustment amount before sequestration  8 SCH or MDH volume decrease adjustment (contractor use only)  70.89 Pioneer ACO demonstration payment adjustment amount (see instructions)  70.89 HSP bonus payment HVBP adjustment amount (see instructions)  70.90 HSP bonus payment HVBR adjustment amount (see instructions)  70.91 HSP bonus payment HVBR adjustment amount (see instructions)  70.92 Bundled Model 1 discount amount (see instructions)  70.93 HVBP payment adjustment amount (see instructions)  70.94 HRR adjustment amount (see instructions)  70.95 O 70.90  70.90 O 70.90		•				ı
70. 75 70. 87 70. 87 70. 88 70. 88 70. 89 70. 90 70. 90 70. 90 70. 91 70. 92 70. 93 70. 94 PI RR adj ustment amount (see instructions)  90 70. 75 70. 87 70. 87 70. 88 90 70. 89 70. 90 10 neer ACO demonstration payment adj ustment amount (see instructions)  91 70. 89 70. 90 70. 91 70. 92 8 undled Model 1 discount amount (see instructions)  92 70. 93 70. 94 PI RR adj ustment amount (see instructions)  93 70. 94 PI Oneer ACO demonstration payment adj ustment amount (see instructions)  94 70. 95 70. 96 70. 97 70. 98 70. 99 70. 91 70. 92 70. 93 70. 94			. (101 301 300 That detroi	13)		1
70. 87 70. 88 70. 88 70. 89 70. 89 70. 90 70. 91 70. 91 70. 91 70. 92 80 80 80 80 80 80 80 80 80 80 80 80 80			tration) adjustment (see	instructions)	0	ł
70. 88 SCH or MDH volume decrease adjustment (contractor use only) 70. 89 Pioneer ACO demonstration payment adjustment amount (see instructions) 70. 90 HSP bonus payment HVBP adjustment amount (see instructions) 70. 91 HSP bonus payment HRR adjustment amount (see instructions) 70. 92 Bundled Model 1 discount amount (see instructions) 70. 93 HVBP payment adjustment amount (see instructions) 70. 94 HRR adjustment amount (see instructions) 70. 94						ł
70.89 Pi oneer ACO demonstration payment adjustment amount (see instructions) 70.90 HSP bonus payment HVBP adjustment amount (see instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 70.92 Bundled Model 1 discount amount (see instructions) 70.93 HVBP payment adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.95 O 70.96						1
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70. 92 Bundled Model 1 discount amount (see instructions) 0 70. 92 HVBP payment adjustment amount (see instructions) 0 70. 93 HRR adjustment amount (see instructions) 0 70. 94		HSP bonus payment HVBP adjustment amount (see instructions)	•			70. 90
70. 93 HVBP payment adjustment amount (see instructions) 0 70. 93 HRR adjustment amount (see instructions) 0 70. 94						•
70.94 HRR adjustment amount (see instructions) 0 70.94						•
		, , , , , , , , , , , , , , , , , , , ,				•
	70. 95	Recovery of accelerated depreciation			0	70. 95

		CN: 15-0005	Peri od: From 01/01/2022 To 12/31/2022	5/31/2023 12:	
	Title	XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
O/ Low values adjustment for foderal figure year (year) (Fater in	aal umn O		0	1. 00	70
.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	COI UIIII U		U	U	70
.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or after			0	0	70
.98 Low Volume Payment-3	er 10/1)			0	70
.99   HAC adjustment amount (see instructions)				153, 687	
.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69	2 & 7O)			18, 613, 680	
.01   Sequestration adjustment (see instructions)	/ Q /O)			234, 532	
.02 Demonstration payment adjustment amount after sequestration				0	1
.03   Sequestration adjustment-PARHM or CHART pass-throughs				J.	71
.00 Interim payments				17, 739, 595	
.01   Interim payments-PARHM or CHART				17, 707, 070	72
.00   Tentative settlement (for contractor use only)				0	
01 Tentative settlement-PARHM or CHART (for contractor use only)				-	73
00 Balance due provider/program (line 71 minus lines 71.01, 71.02,	72. and			639, 553	
73)	,			22., 222	' '
01 Balance due provider/program-PARHM or CHART (see instructions)					74
00 Protested amounts (nonallowable cost report items) in accordance	ce with			217, 506	75
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					İ
00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	f 2.03			0	90
plus 2.04 (see instructions)					
00 Capital outlier from Wkst. L, Pt. I, line 2				0	91
00 Operating outlier reconciliation adjustment amount (see instruc	ctions)			0	92
00 Capital outlier reconciliation adjustment amount (see instructi	ons)			0	93
00 The rate used to calculate the time value of money (see instruc	ctions)			0. 00	94
OD Time value of money for operating expenses (see instructions)				0	
.00  Time value of money for capital related expenses (see instructi	ons)			0	96
			Prior to 10/1		
LIOD D			1.00	2. 00	
HSP Bonus Payment Amount				0	1100
0.00 HSP bonus amount (see instructions)			0	0	100
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment					
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment .00 HVBP adjustment factor (see instructions)	1		0. 0000000000	0. 0000000000	10°
D.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instructions)	)			0. 0000000000	101
D.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment  1.00 HVBP adjustment factor (see instructions)  2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment	)		0. 0000000000	0. 0000000000 0	101 102
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 0.00 HVBP adjustment factor (see instructions) 0.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 0.00 HRR adjustment factor (see instructions)	)		0. 0000000000	0. 0000000000	101 102 103
D. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) HRR Adjustment factor (see instructions) HRR Adjustment amount for HSP bonus payment (see instructions)		ustment	0. 0000000000	0. 0000000000	101 102 103
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 0.00 HVBP adjustment factor (see instructions) 0.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 0.00 HRR adjustment factor (see instructions) 1.00 HRR adjustment amount for HSP bonus payment (see instructions) 1.00 HRR adjustment amount for HSP bonus payment (see instructions) 1.00 Rural Community Hospital Demonstration Project (§410A Demonstration)	ation) Adj		0. 0000000000	0. 0000000000 0 0. 0000 0	101 102 103 104
D. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment D. 00 HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration of the current 5-year demonstration peri	ation) Adj		0. 0000000000	0. 0000000000 0 0. 0000 0	101 102 103 104
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 0.00 HVBP adjustment factor (see instructions) 0.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 0.00 HRR adjustment factor (see instructions) 1.00 HRR adjustment amount for HSP bonus payment (see instructions) 1.00 HRR adjustment amount for HSP bonus payment (see instructions) 1.00 Rural Community Hospital Demonstration Project (§410A Demonstration)	ation) Adj		0. 0000000000	0. 0000000000 0 0. 0000 0	101 102 103 104
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) 0.00 Is this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ation) Adji od under		0. 0000000000	0. 000000000 0 0. 0000 0	101 102 103 104
D. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1. 00 HVBP adjustment factor (see instructions) 2. 00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) NOU Is this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	ation) Adji od under		0. 0000000000	0. 000000000 0 0. 0000 0	101 102 103 104 200
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 0.01 HVBP adjustment factor (see instructions) 0.02 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 0.00 HRR adjustment factor (see instructions) 1.00 HRR adjustment amount for HSP bonus payment (see instructions) 1.00 HRR adjustment amount for HSP bonus payment (see instructions) 1.00 Rural Community Hospital Demonstration Project (§410A Demonstration of Is this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no. 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line of Case-mix adjustment factor (see instructions) 1.00 Case-mix adjustment factor (see instructions)	ation) Adju od under 49)	the 21st	0. 0000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101 102 103 104 200
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment  ON HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment  ON HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Is this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  ON Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)	ation) Adju od under 49)	the 21st	0. 0000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101 102 103 104 200
0.00 HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  .00 HVBP adjustment factor (see instructions)  8.00 HVBP adjustment amount for HSP bonus payment (see instructions)  HRR Adjustment for HSP Bonus Payment  8.00 HRR adjustment factor (see instructions)  8.00 HRR adjustment factor (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstra	ation) Adju od under 49)	the 21st	0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203
D. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment  .00 HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment  B. 00 HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project	ation) Adju od under 49)	the 21st	0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203
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HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment  ON HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment  ON HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Is this the first year of the current 5-year demonstration periodentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  ON Medicare inpatient service costs (from Wkst. D-1, Pt. II, line) Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fperiod)  ON Medicare target amount  ON Medicare inpatient routine cost cap (line 202 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	ation) Adju od under 49)	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 trati on	101 102 103 104 200 201 202 203 204 205
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment  ON HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment  ON HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Is this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  ON Medicare inpatient service costs (from Wkst. D-1, Pt. II, line) Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in feer) Medicare target amount  ON Medicare inpatient routine cost cap (line 202 times line 204) Adjustment to Medicare Part A Inpatient Reimbursement	ation) Adju od under 49) First year	the 21st	0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0	200 201 202 203 204 205 206
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment  ON HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration of 1s this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  ON Medicare inpatient service costs (from Wkst. D-1, Pt. II, line did care discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fine of 1) Demonstration Target Amount Limita	ation) Adju od under 49) First year	the 21st	0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0 tration	200 201 202 203 204 205 206 206
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment  ON HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment  ON HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration)  ON Is this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  ON Medicare inpatient service costs (from Wkst. D-1, Pt. II, line) Computation of Demonstration Target Amount Limitation (N/A in feeriod)  ON Medicare target amount  ON Medicare target amount  ON Medicare inpatient routine cost cap (line 202 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement  ON Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I	ation) Adju od under 49) First year	the 21st	0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0	102 103 104 200 201 202 203 204 205 206 207 208
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment  .00 HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment  8.00 HRR adjustment factor (see instructions) HRR adjustment factor (see instructions)  8.00 HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (See instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (See instructions) Rural Community Hospital Demonstration Project (See instructions) Rural Community Hospital Demonstration Project (See instructions)  8.00 Lis this the first year of the current 5-year demonstration period (See instructions)  8.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Project (See instructions)  8.00 Cosse-mix adjustment factor (see instructions)  8.00 Medicare target amount  8.00 Medicare target amount  8.00 Medicare inpatient routine cost cap (line 202 times line 205)  8.00 Adjustment to Medicare Part A Inpatient Reimbursement  8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Input (See instructions)	ation) Adju od under 49) First year	the 21st	0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 209
D. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) PVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Rural Community Hospital Demonstration Project (§410A Demonstration) Rural Community Hospital Demonstration Project (§410A Demonstration) Is this the first year of the current 5-year demonstration perions Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line) 2.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in feriod) 1.00 Medicare target amount 1.00 Medicare target amount 1.00 Medicare inpatient routine cost cap (line 203 times line 204) 1.00 Medicare inpatient routine cost cap (line 202 times line 205) 1.00 Adjustment to Medicare Part A Inpatient Reimbursement 1.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) 1.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) 1.00 Medicare Fart A inpatient service costs (from Wkst. E, Pt. A, I) 1.00 Medicare Medicare IPPS payments (see instructions) 1.00 Medicare for future use	ation) Adju od under 49) First year	the 21st	0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101 102 103 104 200 203 204 205 206 207 208 209 210
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment  ON HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment  ON HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Rural Community Hospital Demonstration Project (§410A Demonstration) Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  ON Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in final period)  ON Medicare target amount  ON Medicare inpatient routine cost cap (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement  ON Program reimbursement under the §410A Demonstration (see instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Id. 200 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Id. 200 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Id. 200 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Id. 200 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Id. 200 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Id. 200 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Id. 200 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Id. 200 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Id. 200 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Id. 200 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Id. 200 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Id. 200 Medicare Part A inpatient service costs (from Wkst. E, Pt. A)  ON Medicare Part A inpatient se	ation) Adju od under 49) First year	the 21st	0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101 102 103 104 200 203 204 205 206 207 208 209 210
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment  ON HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration)  ON HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Contury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  ON Medicare inpatient service costs (from Wkst. D-1, Pt. II, line) Cost Reimbursement  ON Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in feeriod)  ON Medicare target amount  ON Medicare target amount  ON Medicare inpatient routine cost cap (line 203 times line 204) Adjustment to Medicare Part A Inpatient Reimbursement  ON Program reimbursement under the §410A Demonstration (see instructions)  ON Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) ON Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) ON Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) ON Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) ON Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) ON Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) ON Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) ON Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) ON Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) ON Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) ON Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) ON Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) ON Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) ON Medicare Part A i	49) First year  uctions) ine 59)	the 21st	0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0	201 207 208 209 209 210 211
D. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1. 00 HVBP adjustment factor (see instructions) 2. 00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration of 1s this the first year of the current 5-year demonstration perion Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line cost Reimbursement adjustment factor (see instructions) 3. 00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in final period) 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times line 204) 6. 00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7. 00 Program reimbursement under the §410A Demonstration (see instructions) 0. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) 0. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) 0. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I) 0. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A) 0. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A) 0. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A) 0. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A) 0. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A) 0. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A) 0. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A) 0. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A) 0. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A) 0. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A) 0. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A) 0. 00 Medicare Part A inpatient s	49) First year  uctions) ine 59)	the 21st	0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0 tration	201 202 203 204 205 206 207 208 209 210 211
D. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1. 00 HVBP adjustment factor (see instructions) 2. 00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Rural Community Hospital Demonstration Project (§410A Demonstration) Rural Community Hospital Demonstration Project (§410A Demonstration) Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line) 2. 00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fine) Deriod) 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7. 00 Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I D. 00 Meserved for future use 1. 00 Total adjustment to Medicare IPPS payments (see instructions)	dion) Adjusted and	of the curre	0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0 tration	101 102 103 104 206 202 203 204 205 206 207 208 208 208 208 210 211

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2022 Part A Exhi bit 4 To 12/31/2022 Date/Time Prepared: Provider CCN: 15-0005

								20 pm
		W/C F D A	A		XVIII	Hospi tal	PPS	
		W/S E, Part A line	E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	0	0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	12, 191, 344	0	12, 191, 344		12, 191, 344	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	4, 307, 547	0		4, 307, 547	4, 307, 547	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to	2. 03	224, 469	0	224, 469		224, 469	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2. 04	19, 303	0		19, 303	19, 303	2. 03
3. 00	instructions) Operating outlier	2. 01	0	0	0	0	0	3.00
4. 00	reconciliation Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
	Indirect Medical Education Adju		0.00000	0.00000		0.00000		
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	O	0	6. 01
	Indirect Medical Education Adju							
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7.00
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	0	9. 01
	Di sproporti onate Share Adjustm							
10.00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0741	0. 0741	0. 0741	0. 0741		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	305, 642	0	225, 845	79, 797	305, 642	11. 00
11. 01	Uncompensated care payments	36. 00	2, 213, 241	0	1, 689, 105	524, 136	2, 213, 241	11. 01
10 00	Additional payment for high per		RD beneficiary		=1	=1		10.00
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	19, 261, 546 0	0	14, 330, 763 0	4, 930, 783 0	19, 261, 546 0	13.00 14.00
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	19, 261, 546	0	14, 330, 763	4, 930, 783	19, 261, 546	15. 00

LOW VC	LOWE CALCULATION EXITED T			Trovider e		From 01/01/2022 To 12/31/2022	Part A Exhibi Date/Time Pre 5/31/2023 12:	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A		Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1. 00	2.00	3. 00	4. 00	5. 00	
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 325, 823	0	989, 51	336, 307	1, 325, 823	16.00
17. 00	Special add-on payments for new technologies	54. 00	55, 906	0	48, 40	7, 500	55, 905	17.00
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	'	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	0	1	0	0	18. 00
19. 00	SUBTOTAL			0	15, 368, 68	5, 274, 590	20, 643, 274	19.00
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1.00	1, 235, 964	0	917, 66	9 318, 295	1, 235, 964	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	(	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	33, 375	0	29, 90	9 3, 466	33, 375	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	(	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	(	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0457	0. 0457	0. 045	0. 0457		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	56, 484	0	41, 93	14, 546	56, 484	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 325, 823	0	989, 51	336, 307	1, 325, 823	26. 00
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
	T	0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 00000	0. 000000	0	27. 00 28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. 00
100.00	Pt. A, line)  Transfer low volume  adjustments to Wkst. E, Pt. A.		Y					100.00

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0005 Peri od: Worksheet E From 01/01/2022 Part A Exhibit 5 Date/Time Prepared: 5/31/2023 12: 20 pm 12/31/2022 Hospi tal Title XVIII Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 12, 191, 344 12, 191, 344 12, 191, 344 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 1 02 4, 307, 547 4, 307, 547 4, 307, 547 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1 04 0 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 2.01 **BPCI** 2.02 224, 469 2.02 Outlier payments for discharges occurring 2.03 224, 469 224, 469 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 19, 303 19, 303 19, 303 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 C 0 0 3.00 Managed care simulated payments 0 4.00 4.00 3.00 Indirect Medical Education Adjustment 0.000000 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22.00 6.00 C 0 6.01 IME payment adjustment for managed care (see 22.01 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8.00 IME adjustment (see instructions) 28.00 0 0 8.00 0 IME payment adjustment add on for managed 0 28 01 r 0 8 01 8 01 0 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 9.00 0 Total IME payment for managed care (sum of 9.01 29.01 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 10.00 Allowable disproportionate share percentage 33.00 0.0741 0.0741 0.0741 (see instructions) 11.00 Di sproporti onate share adjustment (see 34.00 305, 642 225, 845 79, 797 305, 642 11.00 instructions) Uncompensa<u>ted care payments</u> 524, 136 11.01 36 00 2, 213, 241 1, 689, 105 2, 213, 241 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12.00 46.00 12.00 instructions) 47.00

19, 261, 546

19 261 546

1, 325, 823

55, 906

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50.00

54.00

68.00

93.00

14, 330, 763

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15, 368, 685

989, 516

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4 930 783

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20, 643, 275 19. 00

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15 00

16.00

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17.01

17.02

18.00

19.00 SUBTOTAL

Subtotal (see instructions)

Wkst. L, Pt. I, if applicable)

Net organ acquisition cost

amount (see instructions)

instructions)

(see instructions)

Hospital specific payments (completed by SCH

and MDH, small rural hospitals only.) (see

Total payment for inpatient operating costs

Payment for inpatient program capital (from

Special add-on payments for new technologies

Credits received from manufacturers for

replaced devices for applicable MS-DRGs

Capital outlier reconciliation adjustment

Heal th	Financial Systems	HENDRI CKS REG	IONAL HEALTH		In lie	u of Form CMS-2	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA		Provider Co	!	Period: From 01/01/2022 Fo 12/31/2022	Worksheet E Part A Exhibi Date/Time Pre 5/31/2023 12:	t 5 pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	1, 235, 964	917, 66	318, 295	1, 235, 964	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	33, 375	29, 90	3, 466	33, 375	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(	0	0	21.01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0457	0. 045	0. 0457		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	56, 484	41, 93	14, 546	56, 484	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 325, 823	989, 51	336, 307	1, 325, 823	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1. 00	2. 00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0			0	28.00
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	0		0	0	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	0		0	0	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		o o	0	
						/ A + + -	

0 70. 99

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

1.00

Υ

(Amt. to Wkst. E, Pt.

2. 00 153, 687

3.00

0

A) 4. 00 153, 687

32.00

100.00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/31/2023 12:20 pm	

Modified and other services (see instructions)   9,447   10.00   10.			Title XVIII	Hospi tal	5/31/2023 12: PPS	20 piii
Mode   Medical and other services (sea instructions)					1 00	
Vertical and other services refine/used under OPPS (see Instructions)   33, 917, 148, 20, 00   OPPS (appeints)   34, 174, 128, 20, 00   OPPS (appeints)   34, 174, 128, 20, 00   OPPS (appeints)   34, 174, 128, 20, 00   0.011   0.		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
3.00   OPPS payments						•
4.00   Outlier payment (see instructions)		,	ons)			1
Surf   Incr   reconcil   Tation amount (see   Instructions)   0.000						1
Line 2 times   Line 5   0   0   0   0   0   0   0   0   0		, , , , , , , , , , , , , , , , , , , ,				1
			ions)			1
Transitional corridor payment (see instructions)						1
Ancil Tary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200   80,334   0,00   10,00   00   00   00   00   00						ł
1.00   Total cost (sum of lines 1 and 10) (see instructions)   9,447   1.00   COMPUTATION OF LESSED OF COST OF CHARGES		, , , , , , , , , , , , , , , , , , , ,	col. 13, line 200			ł
COMPUTATION OF ITSSER OF COST OR CHARGES   2,000   Ancil lary service charges   34,024   12,00   Organ acquisition charges (from West, D-4, Pt. III, col. 4, Iline 69)   34,024   12,00   Organ acquisition charges (from West, D-4, Pt. III, col. 4, Iline 69)   3,4,024   12,00   Organ acquisition charges (from West, D-4, Pt. III, col. 4, Iline 69)   3,4,024   14,00   13,00   Organ acquisition charges (from West, D-4, Pt. III, col. 4, Iline 69)   3,4,024   14,00   15,00   Against anount acctually coll extend from patients I liable for payment for services on a charge basis   0   15,00   Against anount acctually coll extend from patients I liable for payment for services on a chargebasis   0   16,00   Against anount acctually coll extend from patients I liable for payment for services on a chargebasis   0   16,00					_	
Reasonable charges	11. 00				9, 447	11.00
12.00   Ancillary service charges   34,024   12.00   13.00   Organ acquisition charges (from West. D.4, Pt. III, col. 4, line 69)   34,024   14.00   13.00   Organ acquisition charges (sum of lines 12 and 13)   14.00   15						
14.00	12.00				34, 024	12.00
Distorary charges			e 69)			1
15.00   Aggregate amount actually collected from patients Hable for payment for services on a charge basis   0   16.00   Aggregate amount actually collected from patients Hable for payment for services on a charge basis   0   16.00   Aggregate amount actually collected from patients Hable for payment for services on a charge basis   0   16.00   Aggregate amount actually collected from payment for services on a charge basis   0   16.00   Aggregate amount actually collected from payment for services on a charge basis   0   16.00   Aggregate amount actually collected from payment for services on a charge basis   0   16.00   Aggregate amount actually collected from payment for services on a charge basis   0   16.00   Aggregate amount actually collected from payment for services on a charge basis   0   16.00   Aggregate amount actually collected from payment for services   0   0.000000   17.00   0.00000   17.00   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.00000000	14. 00				34, 024	14.00
16.00   Amounts that would have been real ized from patients liable for payment for services on a chargebasis had been made in accordance with 42 CFR \$413.13(e)   17.00   1	15 00		wment for services on	a charge hasis	0	15 00
had such payment been made in accordance with 42 CFR \$413.13(e)					_	
18.00   Total customary charges (see instructions)   34, 024   18.00   10.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   24, 577   19.00   20.00		·	,	J		
19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   24,577   19.00						ı
Instructions			if line 10 exceeds li	no 11) (soo		
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)   0.20.00	17.00	, , ,	II IIIIe 10 exceeus II	ile II) (See	24, 377	19.00
21.00   Lesser of cost or charges (see instructions)   9, 447   21.00   022.00   Cost of physicians' services in a teaching hospital (see instructions)   0.22.00   023.00   024.00   074.00	20.00		if line 11 exceeds li	ne 18) (see	0	20.00
22.00   Interns and residents (see instructions)   0   22.00   0   23.00   0   25.00   17.00	04 00					
23.00   Cost of physicians' services in a teaching hospital (see instructions)   27,945,818   24,00   10   10   10   10   10   10   10		, , , , , , , , , , , , , , , , , , ,				1
24. 00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   27,945,818   24. 00			ctions)		_	ı
25.00   Deductibles and coinsurance amounts (for CAH, see instructions)   5,024,324 26,00			311 3113)		_	•
26. 00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see Instructions)   5. 024, 324   26. 00   27. 00						
27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   22,930,941   27. 00   10   10   10   10   10   10   10			04 (for CALL occ inctr	wati ana)	_	1
Instructions				,		•
29 00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29 00   00   00   00   00   00   00	27.00		us the sum of fines 22	ana 20] (300	22, 730, 741	27.00
Subtotal (sum of lines 27 through 29)   22, 930, 941   30. 00   30. 00   7 marry payer payments   7, 438   31. 00   32. 00   32. 00   32. 00   33. 00   34	28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28. 00
31. 00   Primarry payer payments					_	1
Subtotal (1 ine 30 minus line 31)						1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   Composite rate ESRD (from Wkst. i -5, line 11)   0   33.00   33.00   Composite rate ESRD (from Wkst. i -5, line 11)   164,741   34.00   34.00   All owable bad debts (see instructions)   164,741   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   107,082   35.00   36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   23,030,585   37.00   37.00   Subtotal (see instructions)   23,030,585   37.00   38.00   MSP-LCC reconciliation amount from PS&R   -1   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Pioneer ACO demonstration payment adjustment amount (see instructions)   0   39.00   39.75   Pomonstration payment adjustment amount before sequestration   0   39.97   39.98   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   23,030,586   40.00   40.01   Sequestration adjustment (see instructions)   23,030,586   40.00   40.02   Demonstration payment adjustment amount after sequestration   29,185   40.01   40.02   Demonstration payment adjustment amount after sequestration   29,185   40.01   40.03   Subtotal (see instructions)   29,185   40.01   40.04   Demonstration payment adjustment amount after sequestration   29,185   40.01   40.03   Interim payments   22,713,384   41.00   41.01   Interim payments   22,713,384   41.00   42.01   Tentative settlement (for contractors use only)   42.01   43.01   Tentative settlement (for contractors use only)   42.01   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00   45.01   Demonstration   45.01   46.02   To that ive settlement (For contractors use only)   43.01   46.00   Protested amounts (see instructions)   0   90.00   47.01   To the complex of the provider/program (see instructions)   0   90.00   48.01   To the complex of the provider program (see instructions)   0   90.00   49.00   Other reconciliation adjustment amount (see in						1
34.00		ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	S)			
35.00						•
36. 00						•
37.00   Subtotal (see instructions)   37.00   38.00   MSP-LCC reconciliation amount from PS&R   -1   38.00   38.00   MSP-LCC reconciliation amount from PS&R   -1   38.00   39.00   39.50   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.57   39.58   39.59   Pioneer ACO demonstration payment adjustment amount (see instructions)   0   39.97   39.98   Partial or payment adjustment amount before sequestration   0   39.97   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.98   40.00   30.00   30.00   30.99		, , , , , , , , , , , , , , , , , , ,	ctions)			•
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50   91 oneer ACO demonstration payment adjustment (see instructions)   39.50   39.50   39.75   39.77   Demonstration payment adjustment amount before sequestration   0   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   23.030,586   40.00   40.01   Sequestration adjustment (see instructions)   290,185   40.01   40.02   Demonstration payment adjustment amount after sequestration   290,185   40.01   40.02   Demonstration adjustment (see instructions)   20.02   40.03   20.03   20.03   41.00   Interim payments   22.713,384   41.00   Interim payments   22.713,384   41.00   41.01   Interim payments   22.713,384   41.00   42.00   Tentative settlement (for contractors use only)   42.01   43.00   Bal ance due provider/program (see instructions)   27,017   43.00   43.01   43.01   43.01   43.01   44.00   Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   40.00   43.01	37.00	Subtotal (see instructions)	,			1
39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   39.75   39.75   39.75   39.75   39.75   39.75   39.75   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.78   39.98   RECOVERY OF ACCELERATED DEPRECIATION   0 39.99   40.00   Subtotal (see instructions)   230,030,586   40.00   40.01   40.02   20.00						
39. 75       N95 respirator payment adjustment amount (see instructions)       0       39. 75         39. 97       Demonstration payment adjustment amount before sequestration       0       39. 98         39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       23, 030, 586       40. 00         40. 01       Demonstration payment adjustment (see instructions)       290, 185       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM or CHART pass-throughs       290, 185       40. 01         41. 01       Interim payments-PARHM or CHART       22, 713, 384       41. 00         41. 01       Interim payments-PARHM or CHART (for contractor use only)       0       42. 01         42. 01       Tentative settlement (for contractors use only)       27, 017       43. 00         43. 00       Balance due provider/program (see instructions)       27, 017       43. 01         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2       0       44. 00		, , ,			0	
39.97   Demonstration payment adjustment amount before sequestration   0   39.97					0	
39. 99 40. 00 50		, , ,			_	
40. 00       Subtotal (see instructions)       23, 030, 586       40. 00         40. 01       Sequestration adj ustment (see instructions)       290, 185       40. 01         40. 02       Demonstration payment adj ustment amount after sequestration       0 40. 02         40. 03       Sequestration adj ustment-PARHM or CHART pass-throughs       22, 713, 384       41. 00         41. 01       Interim payments       22, 713, 384       41. 00         41. 01       Tentative settlement (for contractors use only)       0 42. 00         42. 01       Tentative settlement -PARHM or CHART (for contractor use only)       27, 017         43. 00       Bal ance due provider/program (see instructions)       27, 017         43. 01       Bal ance due provider/program-PARHM (see instructions)       27, 017         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00       0 45. 00         90. 00       Oig inal 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 (see instructions)       0 93. 00		· ·	d devices (see instruc	tions)	0	ł
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM or CHART pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM or CHART 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{815.2}{815.2}\$  TO BE COMPLETED BY CONTRACTOR  90.00 Outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier amount (see instructions) 95.00 Time Value of Money (see instructions) 96.00 Outlier amount (see instructions) 97.00 Outlier amount (see instructions)					_	
40. 02 Demonstration payment adjustment amount after sequestration  40. 03 Sequestration adjustment-PARHM or CHART pass-throughs  41. 00 Interim payments  41. 01 Interim payments-PARHM or CHART  42. 00 Tentative settlement (for contractors use only)  42. 01 Tentative settlement-PARHM or CHART (for contractor use only)  43. 00 Balance due provider/program (see instructions)  43. 01 Balance due provider/program-PARHM (see instructions)  44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00  90. 00 Original outlier amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  92. 00 The rate used to calculate the Time Value of Money  93. 00 Time Value of Money (see instructions)  94. 0. 02  94. 0. 02  94. 0. 02  94. 0. 03  94. 0. 04  95. 05 Figure 1, 0 90  96. 00  97. 00  98. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00						
40.03   Sequestration adjustment-PARHM or CHART pass-throughs   40.03   41.00   Interim payments   42.713, 384   41.00   41.01   Interim payments-PARHM or CHART   41.01   42.00   Tentative settlement (for contractor use only)   42.01   Tentative settlement-PARHM or CHART (for contractor use only)   42.01   43.00   Balance due provider/program (see instructions)   27,017   43.00   43.01   Balance due provider/program-PARHM (see instructions)   43.01   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00   44.00   70   70   70   70   70   70   70						
1.01   Interim payments-PARHM or CHART						
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 O 93.00					22, 713, 384	
42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Time Value of Money (see instructions) 95.00 Time Value of Money (see instructions) 96.00 Time Value of Money (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Time Value of Money (see instructions) 97.00 Time Value of Money (see instructions)					0	ı
43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Si15.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  93.00 Time Value of Money (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  96.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)		•				
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{5115.2}\$ \tag{10.00} PECOMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Option of Money (see instructions)  94.00 Option of Money (see instructions)  95.00 Option of Money (see instructions)  97.00 Option of Money (see instructions)  98.00 Option of Money (see instructions)					27, 017	
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00	43. 01					43. 01
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 92.00  93.00 Time Value of Money (see instructions) 0 93.00	44.00		e with CMS Pub. 15-2,	chapter 1,	0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00	90. 00				Ο	90.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00					_	
	92.00	The rate used to calculate the Time Value of Money				•
94.00   Total (Suiii of Titles 91 and 93)						•
	94.00	Tiotai (Suiii Oi Tities at aliu as)			0	74.00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od:	Worksheet E	
		From 01/01/2022		
		To 12/31/2022		
			5/31/2023 12	:20 pm
	Title XVIII	Hospi tal	PPS	
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days				0 200. 00

Peri od: Worksheet E-1 From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/31/2023 12:20 pm Provi der CCN: 15-0005

					5/31/2023 12:2	20 pm
			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		17, 678, 04	9	22, 536, 850	1. 00
2.00	Interim payments payable on individual bills, either			o	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)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER	12/31/2022	15.04	6 12/31/2022	176, 534	3. 01
3. 01	ADJUSTMENTS TO PROVIDER	10/05/2022	15, 84 45, 70		176, 534	3. 01
3. 02		10/03/2022		0		3. 02
3. 04				0		3. 03
3. 05				o		3.05
3.03	Provider to Program			<u> </u>	0	3.03
3. 50	ADJUSTMENTS TO PROGRAM			ol	0	3. 50
3. 51	THE STATE OF THE S			0	0	3. 51
3. 52				O	0	3. 52
3. 53				O	0	3. 53
3.54				o	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		61, 54	6	176, 534	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		17, 739, 59	5	22, 713, 384	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR					F 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			ol	0	5. 01
5. 02	TENTITIVE TO TROVIDER			o	l ő	5. 02
5. 03				Ö	l ol	5. 03
	Provider to Program			- 1		
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		,,,,		07.017	, 61
6. 01	SETTLEMENT TO PROVIDER		639, 55		27, 017	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		18, 379, 14	Contractor	22, 740, 401 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8. 00
00				T.		00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2023 12:20 pm

			10 12/31/2022	5/31/2023 12:	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		1, 795, 083		1.00
2.00	Medical and other services			0	2.00
	Organ acquisition (certified transplant programs only)		0		3.00
	Subtotal (sum of lines 1, 2 and 3)		1, 795, 083	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)		1, 795, 083	0	7.00
İ	COMPUTATION OF LESSER OF COST OR CHARGES				1
j	Reasonabl e Charges				1
8.00	Routine service charges		2, 921, 167		8.00
9.00	Ancillary service charges		4, 027, 466	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)		6, 948, 633	0	12.00
İ	CUSTOMARY CHARGES				1
13.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.00
	basis				
	Amounts that would have been realized from patients liable fo		0	0	14.00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
	Total customary charges (see instructions)		6, 948, 633	0	
17. 00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	5, 153, 550	0	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds line	0	0	18.00
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see inst		0	0	
	Cost of covered services (enter the lesser of line 4 or line		1, 795, 083	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid			
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0	0	25.00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	-	
	Customary charges (title V or XIX PPS covered services only)		1 705 000	0	
	Titles V or XIX (sum of lines 21 and 27)		1, 795, 083	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	30.00
	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	`	1, 795, 083	0	
	Deductibles	)	1, 795, 083	0	
	Coinsurance		10, 093	0	02.00
	Allowable bad debts (see instructions)		10, 093	0	
	Utilization review		0	Ü	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	4 33)	1, 784, 990	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	u 33)	1, 764, 990	0	
	Subtotal (line 36 ± line 37)		1, 784, 990	0	
	Direct graduate medical education payments (from Wkst. E-4)		1, 704, 990	U	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		1, 784, 990	0	
	Interim payments		2, 513, 569	0	
	Balance due provider/program (line 40 minus line 41)		-728, 579	0	
	, , , , , , , , , , , , , , , , , , , ,	ONC D L 45 0	1	-	
	Protested_amounts_(nonallowable_cost_report_items) in accorda	NCE WITH UMS PUN 15-7	(1)	(1)	
43.00	Protested amounts (nonallowable cost report items) in accordance chapter 1, §115.2	nce with CMS Pub 15-2,	0	0	43.00

Heal th	alth Financial Systems HENDRICKS REGIONAL HEALTH In Lieu		u of Form CMS-2	552-10	
			Worksheet E-5		
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/31/2023 12:2	oared: 20 pm_
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus 2.04 (see	instructions)	0	1.00
2.00 Capital outlier from Wkst. L, Pt. I, line 2				0	2.00
3.00 Operating outlier reconciliation adjustment amount (see instructions)				0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)			0	4.00	
5.00 The rate used to calculate the time value of money (see instructions)			0.00	5.00	
6.00 Time value of money for operating expenses (see instructions)					6.00
7.00	Time value of money for capital related expenses (see instru	ctions)		0	7.00

Health Financial Systems

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

Provider CCN: 15-0005

| Peri od: From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: | 5/31/2023 12:20 pm

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oni y)					5/31/2023 12:	20 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1. 00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS		2.00	0.00	11.00	
1.00	Cash on hand in banks	12, 172, 927			0	
2.00	Temporary investments	C	0	· ·	0	
3.00	Notes receivable	(	0		0	
4.00	Accounts receivable	158, 703, 817	0 0		0	
5. 00 6. 00	Other receivable Allowances for uncollectible notes and accounts receivable	-119, 496, 288		· ·	0	
7. 00	Inventory	4, 423, 159		· · · · · · · · · · · · · · · · · · ·	0	
8. 00	Prepai d expenses	7, 084, 611	1	_	0	
9. 00	Other current assets	29, 974, 283	1		0	
10.00	Due from other funds	68, 807		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	92, 931, 316	0	0	0	11.00
40.00	FI XED ASSETS	04 705 07				1
12.00	Land	21, 705, 276	1		0	
13. 00 14. 00	Land improvements Accumulated depreciation	10, 231, 133 -8, 670, 694		· ·	0	
15. 00	Buildings	306, 684, 161	1		0	1
	Accumulated depreciation	-148, 953, 642		· ·	0	1
17. 00	Leasehold improvements	C	o		0	1
18.00	Accumul ated depreciation	C	0	0	0	18.00
	Fixed equipment	C	0		0	
	Accumulated depreciation	C	0	· ·	0	
	Automobiles and trucks		0		0	
	Accumulated depreciation	160, 037, 394	0	· ·	0	
	Major movable equipment Accumulated depreciation	-115, 488, 941	1		0	1
	Mi nor equi pment depreciable	-115, 466, 741		· ·	0	1
26. 00	Accumulated depreciation		ol o		0	1
	HIT designated Assets	Ċ	o	0	0	27.00
28. 00	Accumulated depreciation	C	0	0	0	28. 00
	Mi nor equi pment-nondepreci abl e	C	0		0	
30. 00	Total fixed assets (sum of lines 12-29)	225, 544, 687	7 0	0	0	30.00
31. 00	OTHER ASSETS Investments	319, 078, 382	2 0	0	0	31.00
32. 00	Deposits on Leases	317,070,302			0	
33. 00	Due from owners/officers	24, 965, 012		· ·	0	1
34.00	Other assets	3, 661, 423	3 o	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	347, 704, 817	1		0	
36. 00	Total assets (sum of lines 11, 30, and 35)	666, 180, 820	0	0	0	36.00
37. 00	CURRENT LIABILITIES Accounts payable	16, 544, 598	3 0	0	0	37.00
	Salaries, wages, and fees payable	13, 746, 174	1		0	
	Payrol I taxes payable	6, 013, 947	•		0	1
40. 00	Notes and Loans payable (short term)	30, 930, 000			0	1
41.00	Deferred income	C	o o	0	0	41.00
42.00	Accel erated payments	3, 842, 644	l			42.00
	Due to other funds	2, 676		· ·	0	
	Other current liabilities	16, 916, 024	1	· ·	0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	87, 996, 063	3 0	0	0	45.00
46. 00	Mortgage payable	93, 358, 796	0	0	0	46.00
47. 00	Notes payable	0	o o		0	
48.00	Unsecured Loans	C	o		0	1
49.00	Other long term liabilities	9, 670, 854	1 0		0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	103, 029, 650			0	
51. 00	Total liabilities (sum of lines 45 and 50)	191, 025, 713	3 0	0	0	51.00
52. 00	CAPITAL ACCOUNTS  General fund balance	475, 155, 107	,			52.00
53. 00	Specific purpose fund	475, 155, 107	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	58.00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	475, 155, 107	, 0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	666, 180, 820	1	· ·	0	
_0.00	[59]	, .50, 520				-5.00
			•	. '		-

Provi der CCN: 15-0005

| Peri od: | Worksheet G-1 | From 01/01/2022 | To | 12/31/2022 | Date/Ti me Prepared:

					To 12/31/2022	Date/Time Pre 5/31/2023 12:	
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) ROUNDING	0 96 0 0	511, 167, 105 -36, 012, 094 475, 155, 011		0 0 0 0 0	0 0 0 0	5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0 0 0 0	96 475, 155, 107		0 0 0 0 0 0 0	0 0 0 0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	Endowment	0 475, 155, 107 PI ant	Fund	0 0		18. 00 19. 00
		Fund	Tranc	- una			
		6. 00	7. 00	8. 00	_		
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) ROUNDING	0.00	0 0 0 0 0	5. 00	0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0	0 0 0 0 0		O O O		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Health Financial Systems HI STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0005

			0 12/31/2022	5/31/2023 12:	pareu: 20 nm
	Cost Center Description	Inpatient	Outpati ent	Total	
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	91, 288, 534		91, 288, 534	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5. 00
6. 00	Swing bed - NF			0	
7. 00	SKILLED NURSING FACILITY			0	
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)	91, 288, 534		91, 288, 534	10.00
44.00	Intensive Care Type Inpatient Hospital Services	11 (00 00)	T.	14 (00 00)	
11.00	INTENSIVE CARE UNIT	11, 609, 906	1	11, 609, 906	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)	11 (00 00)		11 (00 00)	15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	11, 609, 906		11, 609, 906	16. 00
17. 00	11-15)	102, 898, 440		102, 898, 440	17. 00
18.00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services	131, 414, 387			18.00
19. 00	Outpatient services	22, 827, 874			1
20. 00	RURAL HEALTH CLINIC	22, 021, 014			20.00
	FEDERALLY QUALIFIED HEALTH CENTER		_		21.00
22. 00	HOME HEALTH AGENCY		0	0	22.00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26.00
27. 00	PRO FEES	1, 994, 804	94, 263, 381	96, 258, 185	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks		1	1, 198, 024, 510	•
20.00	G-3, line 1)	207, 100, 000	700,007,000	1, 170, 021, 010	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		438, 583, 914		29. 00
30.00	ADD (SPECIFY)				30.00
31.00			1		31.00
32.00			1		32.00
33.00			1		33.00
34.00			1		34.00
35.00					35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)				37.00
38. 00					38. 00
39. 00					39. 00
40.00			)		40.00
41.00		C			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	sfer	438, 583, 914		43.00
	to Wkst. G-3, line 4)			l	l

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Fo					
STATEN	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0005	Peri od: From 01/01/2022	Worksheet G-3	
	To 12/31/2022				
				5/31/2023 12:	20 pm
4 00	Total and the desired of the second of the s	20)		1.00	1 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			1, 198, 024, 510	1.00
2.00	Less contractual allowances and discounts on patients' accounts and discounts on patients' accounts and discounts on patients' accounts and discounts on patients' accounts and discounts on patients' accounts and discounts on patients' accounts and discounts on patients' accounts and discounts on patients' accounts and discounts on patients' accounts and discounts on patients' accounts and discounts on patients' accounts and discounts on patients' accounts and discounts are accounts.	nts		774, 651, 587	2.00
3.00	Net patient revenues (line 1 minus line 2)	12)		423, 372, 923	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		438, 583, 914	4.00
5. 00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			-15, 210, 991	5. 00
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			-36, 506, 397	7. 00
8. 00	Revenues from telephone and other miscellaneous communication	n sarvi cas		-30, 300, 377	8.00
9. 00	Revenue from television and radio service	ii sei vi ces		0	
10.00	Purchase di scounts			o o	10.00
11. 00	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13. 00
14. 00	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
	Revenue from sale of drugs to other than patients			0	17. 00
	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER OPERATING REVENUE			10, 408, 870	24.00
24. 01	NON OPERATING REVENUE			3, 645, 756	24. 01
24. 50	COVI D-19 PHE Fundi ng			1, 650, 668	24.50
25.00	Total other income (sum of lines 6-24)			-20, 801, 103	25.00
26.00	Total (line 5 plus line 25)			-36, 012, 094	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			-36, 012, 094	29. 00

Heal th	Financial Systems HENDRICKS REGION	NAL HEALTH	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0005	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
1 00	CAPITAL FEDERAL AMOUNT			1 225 0/4	1 00
1. 00 1. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier			1, 235, 964 0	1. 00 1. 01
2. 00	Capital DRG outlier payments			33, 375	ł
2. 01	Model 4 BPCI Capital DRG outlier payments			0 33, 373	2.01
3.00	Total inpatient days divided by number of days in the cost re	eportina period (see ins	tructions)	60. 61	
4.00	Number of interns & residents (see instructions)	3   1	,	0.00	4.00
5.00	Indirect medical education percentage (see instructions)			0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the	e 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 Part A	patient days (Worksheet	E, part A line	1. 18	7. 00
0.00	30) (see instructions)	uati ana)		20.00	8.00
8. 00 9. 00	Percentage of Medicaid patient days to total days (see instructions of lines 7 and 8	uctions)		20. 88 22. 06	1
10.00	Allowable disproportionate share percentage (see instructions	e)		4. 57	
11. 00	Disproportionate share adjustment (see instructions)	3)		56, 484	
12. 00	, , , , , , , , , , , , , , , , , , , ,			1, 325, 823	
	, , , , , , , , , , , , , , , , , , ,				
	DADT II. DAVMENT INDED DEACONADIE COCT			1. 00	
1. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1.00
2. 00	Program inpatient ancillary capital cost (see instructions)			0	
3. 00	Total inpatient program capital cost (line 1 plus line 2)			Ö	
4. 00	Capital cost payment factor (see instructions)			0	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
				4.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00	
1. 00	Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs for extraordinary circumstan	ces (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)	,		0	3.00
4.00	Applicable exception percentage (see instructions)			0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	
6.00	Percentage adjustment for extraordinary circumstances (see i			0.00	ł
7. 00	Adjustment to capital minimum payment level for extraordinary	y circumstances (line 2	x line 6)	0	
8. 00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as appl		1 1	0	
10. 00 11. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over	1 1 3 1	,	0	
11.00	Worksheet L, Part III, Line 14)	capital payment (110m pi	i oi yeai	0	11.00
12.00	Net comparison of capital minimum payment level to capital page 1	ayments (line 10 plus li	ne 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, ente	r the amount on this lin	e)	0	
14. 00	Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	capital payment for the	following period	0	14.00
15. 00	Current year allowable operating and capital payment (see in:	structions)		0	15. 00
16. 00	, , , , , , , , , , , , , , , , , , , ,			Ö	
	Current year exception offset amount (see instructions)			-	17. 00
			!		