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: 15-0030 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/26/2023 3:03 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/26/2023 3: 03 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.

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

(4) Reopened(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HENRY COUNTY MEMORIAL HOSPITAL (15-0030) for the cost reporting period beginning 01/01/2022 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	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1			SIGNATURE STATEMENT	
1	Dai	rin Brown	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Darin Brown			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		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	164, 120	-24, 550	0	-131, 213	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	2		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		151, 994		0	10.00
10. 01	RURAL HEALTH CLINIC II	0		342, 664		0	10. 01
10. 02	RURAL HEALTH CLINIC III	0		37, 251		0	10. 02
200.00	TOTAL	0	164, 120	507, 361	0	-131, 213	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.

In Lieu of Form CMS-2552-10 Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0030 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/26/2023 3:03 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1000 NORTH 16TH STREET 1.00 PO Box: 1.00 State: IN 2.00 City: NEW CASTLE Zip Code: 47392-County: HENRY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 HENRY COUNTY MEMORIAL 150030 99915 07/01/1996 N 0 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospital -Based NF 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA HCMH HOME CARE 157430 99915 06/14/1995 Ρ Ν 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce HOSP-BASED HOSPICE 151564 99915 14.00 08/31/1998 14.00 NEW CASTLE FAMILY AND Hospital-Based Health Clinic - RHC 0 15.00 158520 99915 04/11/2017 N 0 15.00 NTERNAL MED Hospital-Based Health Clinic - RHC NCFIM - NORHTFIELD PARK 158525 99915 15.01 15.01 12/04/2017 0 0 15.02 Hospital -Based Health Clinic - RHC CAMBRIDGE CITY FAMILY 158556 0 99915 06/02/2020 0 15 02 N 1111 HEALTH PARTNER Hospital-Based Health Clinic - FQHC 16.00 Hospital -Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 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 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 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 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 22.02 Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν 22.03 Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

					10 12/3	31/2022		023 3:0	epared: 03 pm		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	id (ther di cai d days	, pin		
	If this provider is an IPPS hospital, enter the 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 columr		2. 00 1, 642	3.00	4.00	5.00	49	6.00	24.00		
25. 00	4, Medicaid HMO paid and eligible but unpaid days ir column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	О	C		0		25. 00		
						Rural S 00		Geogr 00	1		
	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo		at the be	ginning of		1		00	26.00		
27. 00	Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban c enter the effective date of the geographic reclassif	wage) status or "2" for r fication in	rural. If a column 2.	ppl i cabl e,		1			27. 00		
	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	ne number of	f periods S	CH status i		0	E . I		35.00		
						ni ng: 00	Endi 2.				
	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		script line	36 for num	nber				36.00		
	of periods in excess of one and enter subsequent dates. OO If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 1										
	7.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in 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 date greater than 1, subscript this line for the number clenter subsequent dates.				01/01	/2022	12/31	/2022	38.00		
	onter subsequent dates.					/N		/N			
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage ii)? Enter	(iii)? En e requireme in column	ter in colu nts in 2 "Y" for y	ume umn ves	00 Y	`	00 (39.00		
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for	Y" for yes yes or "N"	or I	N	1	I	40.00		
	ino Titi dei diini 2, Toi di sendi ges en el di tel detabel i	1. (300 1113)	1 40 (1 0113)			V	XVIII				
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00			
	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	ent for disp	proporti ona	te share ir	accordanc	e N	N	N	45. 00		
46. 00	Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46.00		
47. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymer	•		-		N N	N N	N N	47. 00 48. 00		
	Teaching Hospitals						I IN	I IN			
	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to convolved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column 2	"Y" for yes er 27, 2020, column 1 is rams in the CRs) MA dir	or "N" fo under 42 "Y", or if prior year	r no in col CFR 413.78(this hospi or penulti	umn 1. For (b)(2), see tal was mate year,				56.00		
	For cost reporting periods beginning prior to December is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no i residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complet complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not complete.	n residents n column 1. cost report te Worksheet applicable R 413.77(e e on duty, i	in approve If column ing period E-4. If column column ing period I be ing period I column I ing period I column I ing period I ing peri	d GME progr 1 is "Y", ? Enter "\ olumn 2 is reporting nd (v), req onse to lir	rams traine did /" for yes "N", periods gardless of ne 56 is "Y	or			57.00		

	instructions) Litter in cordini i, the program name.								
	Enter in column 2, the program code. Enter in column	า							
	3, 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)								
62.00	Enter the number of FTE residents that your hospital	iod for which	0. 00	62.00					
	your hospital received HRSA PCRE funding (see instru	uctions)							
62.01	Enter the number of FTE residents that rotated from	a Teaching Health Cen	ter (THC) into	your hospital	0. 00	62. 01			
	during in this cost reporting period of HRSA THC pro	ogram. (see instructio	ns)	•					
	Teaching Hospitals that Claim Residents in Nonprovi	der Settings							
63.00	Has your facility trained residents in nonprovider s	settings during this c	ost reporting	period? Enter	N	63.00			
	"Y" for yes or "N" for no in column 1. If yes, compl	ete lines 64 through	67. (see instr	uctions)					
		<u> </u>							

Health Financial Systems		NTY MEMORIAL HOSPIT			u of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COM	PLEX IDENIIFICATION DA	ATA Provider		Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Pre 5/26/2023 3:0	pared:
		,	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	5 piii
			Si te	· ·	, ,	
Section 5504 of the ACA Base Ye period that begins on or after			1.00 sThis base yea	2.00 ar is your cost	3.00 reporting	
64.00 Enter in column 1, if line 63 i in the base year period, the nu resident FTEs attributable to r settings. Enter in column 2 th resident FTEs that trained in y	s yes, or your facili mber of unweighted no otations occurring in e number of unweighte	ty trained resident n-primary care all nonprovider d non-primary care		0.00	0. 000000	64.00
of (column 1 divided by (column	1 + column 2)). (see	instructions)				
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 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)			Unwei ghted	Unwei ghted	0.000000	65.00
			FTEs Nonprovi der Si te	FTEs in	1/ (col . 1 + col . 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 2		n Nonprovider Sett	ingsEffective	for cost report	ing periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column	rovider settings. ry care resident 3 the ratio of	0. (0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	·	Ratio (col. 3/ (col. 3 + col. 4))	
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		2.00	3.00	4.00	5, 00 0, 000000	67.00
your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						

Health Financial Systems HENRY COUNT	TY MEMORIAL HOSPITAL		In	Li eu	of Form	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA Provider CC	F	Period: From 01/01/2 Fo 12/31/2	2022	Workshee Part I Date/Tir 5/26/202	me Pre	pared:
				-	1. 00	0	
Direct GME in Accordance with the FY 2023 IPPS Final 68.00 For a cost reporting period beginning prior to Octobe MAC to apply the new DGME formula in accordance with (August 10, 2022)?	r 1, 2022, did you o	btain permiss	ion from you		N		68. 00
				1. 00	2. 00	3. 00	
Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (I	PF), or does it cont	ain an IPF su	bprovi der?	N			70. 00
Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an recent cost report filed on or before November 15, 20 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this faci program in accordance with 42 CFR 412.424 (d)(1)(iii) Column 3: If column 2 is Y, indicate which program ye (see instructions)	04? Enter "Y" for y lity train residents (D)? Enter "Y" for y	es or "N" for in a new tea es or "N" for	no. (see chi ng no.			0	71. 00
Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility	(IRF), or does it c	ontain an IRF		N			75. 00
subprovider? Enter "Y" for yes and "N" for no. 16 line 75 is yes: Column 1: Did the facility have an recent cost reporting period ending on or before Nove no. Column 2: Did this facility train residents in a CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" indicate which program year began during this cost re	mber 15, 2004? Enter new teaching program for no. Column 3: If	"Y" for yes in accordance column 2 is	or "N" for e with 42 Y,			0	76. 00
				-	1. 00	0	
80.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" Is this a LTCH co-located within another hospital for "Y" for yes and "N" for no. TEFRA Providers			g period? Er	nter	N N		80. 00 81. 00
85.00 Is this a new hospital under 42 CFR Section §413.40(f) 86.00 Did this facility establish a new Other subprovider (§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				no.	N		85. 00 86. 00
87.00 Is this hospital an extended neoplastic disease care 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	hospital classified	under section			N		87. 00
			Approved Permaner Adjustme (Y/N) 1.00	nt	Number Approv Perman Adjustm 2.00	ved nent nents	
88.00 Column 1: Is this hospital approved for a permanent a amount per discharge? Enter "Y" for yes or "N" for no 89. (see instructions) Column 2: Enter the number of approved permanent adju	. If yes, complete c		е			0	88. 00
		Wkst. A Line No.	Effectiv Date	/e	Appro Perman Adjusti Amount Discha	nent ment Per arge	
89.00 Column 1: If line 88, column 1 is Y, enter the Worksh	eet A line number	1.00	2. 00		3. 00		89. 00
on which the per discharge permanent adjustment appro Column 2: Enter the effective date (i.e., the cost re beginning date) for the permanent adjustment to the T per discharge. Column 3: Enter the amount of the approved permanent	val was based. porting period EFRA target amount						
TEFRA target amount per discharge.			V		XIX	(
Title V and XIX Services			1. 00		2. 00	0	
90.00 Does this facility have title V and/or XIX inpatient yes or "N" for no in the applicable column.	hospital services? E	nter "Y" for	N		Υ		90.00
91.00 Is this hospital reimbursed for title V and/or XIX the full or in part? Enter "Y" for yes or "N" for no in t			N		Υ		91.00
92.00 Are title XIX NF patients occupying title XVIII SNF binstructions) Enter "Y" for yes or "N" for no in the	eds (dual certificat				N		92.00
93.00 Does this facility operate an ICF/IID facility for pu "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N		N		93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" fo applicable column.	r yes, and "N" for n	o in the	N		N		94.00
95.00 If line 94 is "Y", enter the reduction percentage in 96.00 Does title V or XIX reduce operating cost? Enter "Y" applicable column.			0. 00 N		O. 00 N	0	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in	the applicable colum	n.	0.00		0.00	0	97.00

Health Financial Systems HENRY COUNTY MEMOR				u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co		Period: From 01/01/2022 To 12/31/2022	Worksheet S- Part I Date/Time Pi 5/26/2023 3:	repared:
			V 1. 00	XI X 2. 00	_
98.00 Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" follow m 1 for title V, and in column 2 for title XIX.			Y	Υ Υ	98.00
98.01 Does title V or XIX follow Medicare (title XVIII) for the report of the control of the con				Υ	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX.			Y	Υ	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critire imbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.				N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add bad Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.				Υ	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost in Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.	reimbursed fo 1 for title	or Wkst. D, V, and in	Y	Y	98. 06
Rural Providers 105.00 Does this hospital qualify as a CAH?			N		105.00
106.00 If this facility qualifies as a CAH, has it elected the all-i	inclusive met	hod of paymen			106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for costraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 2: If column 1 is Y and line 70 or line 75 is Y, do yet the column 2: If column 1 is Y and line 70 or line 75 is Y, do yet the column 2: If column 1 is Y and line 70 or line 75 is Y, do yet the column 2: If column 1 is Y and line 70 or line 75 is Y, do yet the column 2: If column 1 is Y and line 70 or line 75 is Y, do yet the column 2: If column 1 is Y and line 70 or line 75 is Y, do yet the column 2: If column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the column 1 is Y and line 70 or line 75 is Y, do yet the Y and I is Y a	1. (see ins	structi ons)	N		107. 00
approved medical education program in the CAH's excluded IPI Enter "Y" for yes or "N" for no in column 2. (see instruction 108.00 is this a rural hospital qualifying for an exception to the	ons)	, ,	N		108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	Physi cal 1.00	Occupati onal 2.00	Speech 3.00	Respiratory 4.00	<u>/</u>
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 00
				1. 00	_
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "'complete Worksheet E, Part A, lines 200 through 218, and Worlapplicable.	Y" for yes or	"N" for no.	If yes,	N N	110.00
			1. 00	2. 00	
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cosmology "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is participated and that apply: "A" for Ambulance services; "B" for additional for tele-health services.	st reporting Iumn 1 is Y, ticipating in	period? Enter enter the column 2.	N		111.00
·					
112.00 Did this hospital participate in the Pennsylvania Rural Heal	11. 14. 1.1	1. 00 N	2.00	3. 00	112. 00
	th Model				1
(PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If col "Y", enter in column 2, the date the hospital began participatemonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access	porting lumn 1 is ating in the sed and Rural				113. 00
(PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If col "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital cease participation in the demonstration, if applicable.	porting lumn 1 is ating in the sed and Rural				113. 00
 (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If col "Y", enter in column 2, the date the hospital began participal demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current of the reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "95" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers) 	porting I umn 1 is ating in the sed and Rural cost "N" for no , or E only) 3" percent includes	N			113. 00 0115. 00
 (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If col "Y", enter in column 2, the date the hospital began participal demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "9" for short term hospital or "98" percent for long term care (in the column care) 	porting I umn 1 is ating in the sed and Rural cost "N" for no , or E only) 3" percent i ncl udes s) based on	N N			

117. 00 118. 00

117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.

Ν

146. 00

146.00 Has the cost allocation methodology changed from the previously filed cost report?

yes, enter the approval date (mm/dd/yyyy) in column 2.

Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If

Health Financial Systems	HENRY COUNTY	/ MEMOF	RIAL HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			Provi der CC	CN: 15-003C			Worksheet S- Part I Date/Time Pr 5/26/2023 3:	2 epared:
							1. 00	-
147.00 Was there a change in the statist	ical basis? Enter "Y"	for v	es or "N" for	no			1.00 Y	147. 00
148.00 Was there a change in the order o							N	148. 00
149.00 Was there a change to the simplif					for no.		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 159. 00 SNF			N	l N		N	N	158. 00 159. 00
160.00HOME HEALTH AGENCY			N	N N		N	N N	160.00
161. OOKHC			IN	N N		N	N	161. 00
						· · · · · ·	1. 00	
Mul ti campus								
165.00 s this hospital part of a Multic Enter "Y" for yes or "N" for no.	t CBSAs?	N	165. 00					
•	Name		County	State	Zip Co	de CBSA	FTE/Campus	
	0		1. 00	2. 00	3. 00	4.00	5. 00	
166.00 f 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	0 166. 00
							1. 00	_
Health Information Technology (HI	T) incentive in the A	meri ca	n Recovery an	nd Rei nves	tment A	ct	1.00	
167.00 Is this provider a meaningful use							Υ	167. 00
168.00 If this provider is a CAH (line 1) reasonable cost incurred for the				e 167 is '	"Y"), eı	nter the		168. 00
168.01 If this provider is a CAH and is	not a meaningful user	, does	this provide	r qualify	for a l	hardshi p		168. 01
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful transition factor. (see instructi	user (line 167 is "Y")) and	is not a CAH	(line 105	is "N")), enter the	9. 9	9169.00
transition ractor. (See Tristracti	0113)					Begi nni ng	Endi ng	
						1.00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and en	ding d	ate for the r	eporti ng				170.00
						1. 00	2. 00	
171.00 If line 167 is "Y", does this pro	vider have any days f	or ind	li vi dual s enro	lled in		N N		0171.00
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3 umn 1. If column 1 is	, Pt.	I, line 2, co	 6? Ente 		·-		

0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0030	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pro 5/26/2023 3:0	epared:
				Y/N 1,00	Date 2 00	+
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEN	MENT OUESTLON	NAI DE	1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			ter all dates in	the	
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			. N		1.0
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	instruction:	s) Date	V/I	
			1.00	2.00	3. 00	
. 00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N	2,00		2.0
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	N			3.0
	The action of the control of the con		Y/N	Type	Date	
			1.00	2. 00	3. 00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.0
. 00	Are the cost report total expenses and total revenues differ		N			5.0
	those on the filed financial statements? If yes, submit reco	onciliation.		Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for a nursing program? Column 2	2: If yes, is	s the provid	er N		6.0
. 00 . 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing programs and/or allied health programs approved	n he N		7. C		
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved of	araduate medi	cal education	n N		9.0
0. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.	S.		N		10.0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.0
					Y/N	
	Bad Debts				1. 00	
2. 00	Is the provider seeking reimbursement for bad debts? If yes,	see instruc	ti ons.		Υ	12.0
3. 00	If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.	olicy change (during this		N	13.0
4.00	If line 12 is yes, were patient deductibles and/or coinsurar instructions. Bed Complement	ice alliounts wa	arved? IT ye:	s, see	N	14.0
5. 00	Did total beds available change from the prior cost reporting				N	15.0
			t A	Par		
		1. 00	2. 00	Y/N 3.00	<u>Date</u> 4. 00	
	PS&R Data					
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	Y	04/27/2023	Y	04/27/2023	16.0
7. 00		N		N		17. C
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.0
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 0

From 01/01/2022 Pa To 12/31/2022 Da	orksheet S- art II ate/Time Pr	-2
	/26/2023 3:	
	Y/N	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R	3. 00 N	20.00
Report data for Other? Describe the other adjustments:	IN	20.00
Y/N Date Y/N	Date	
1.00 2.00 3.00	4. 00	
21.00 Was the cost report prepared only using the provider's N N records? If yes, see instructions.		21. 00
	1. 00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)	1.00	
Capital Related Cost		
22.00 Have assets been relifed for Medicare purposes? If yes, see instructions	N	22. 00
23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost	N	23. 00
reporting period? If yes, see instructions.		
24.00 Were new Leases and/or amendments to existing Leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see	N	25. 00
i nstructi ons.		
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26. 00
27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit	N	27. 00
сору.		
Interest Expense		
28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Υ	28. 00
29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)	N	29.00
treated as a funded depreciation account? If yes, see instructions		
30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see	N	31.00
instructions.		
Purchased Services		
32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If	N	33.00
no, see instructions.		
Provi der-Based Physi ci ans		
34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians?	Υ	34.00
If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based	N	35.00
physicians during the cost reporting period? If yes, see instructions.		
Y/N Y/N	Date	
1.00	2. 00	
Home Office Costs 36.00 Were home office costs claimed on the cost report? N		36.00
36.00 Were home office costs claimed on the cost report? N 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N		37.00
If yes, see instructions.		07.00
38.00 If line 36 is yes , was the fiscal year end of the home office different from that of N		38. 00
the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes,		39.00
see instructions.		37.00
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see		40.00
i nstructi ons.		
1.00 2.00		
Cost Report Preparer Contact Information		
41.00 Enter the first name, last name and the title/position KYLE SMITH		41.00
held by the cost report preparer in columns 1, 2, and 3,		
respectively. 42.00 Enter the employer/company name of the cost report BLUE & CO., LLC		42.00
preparer.		#2.00
43.00 Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO.	D. COM	43.00
report preparer in columns 1 and 2, respectively.		11

Financial Systems HENRY COUNTY	MEN	MORIAL HOSPITAL		In Lieu of Form CMS-2552-10				
TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0030						
					Date/Time Pre	pared: 3 pm		
		3. 00						
Cost Report Preparer Contact Information								
Enter the first name, last name and the title/position		DI RECTOR				41.00		
held by the cost report preparer in columns 1, 2, and 3	,							
respecti vel y.								
Enter the employer/company name of the cost report						42.00		
preparer.								
Enter the telephone number and email address of the cos	t					43.00		
report preparer in columns 1 and 2, respectively.								
	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. Enter the telephone number and email address of the cost	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. Enter the telephone number and email address of the cost	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0030 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0030 Factor	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0030 Period: From 01/01/2022 To 12/31/2022 Provider CCN: 15-0030 Period: From 01/01/2022 Provider CCN: 15-0030	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0030 Period: From 01/01/2022 To 12/31/2022 Part II Date/Time Pre 5/26/2023 3:0 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. Enter the telephone number and email address of the cost		

Health Financial Systems In Lieu of Form CMS-2552-10 HENRY COUNTY MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0030 Peri od: Worksheet S-3 From 01/01/2022 Part I 12/31/2022 Date/Time Prepared: 5/26/2023 3:03 pm I/P Days / 0/P Visits / Tri ps CAH Hours Component Worksheet A No. of Beds Bed Days Title V Li ne No. Avai I abl e 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 38 13, 870 0.00 0 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 2.00 3.00 HMO IPF Subprovider HMO IRF Subprovider 3.00 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 13, 870 7.00 38 0.00 0 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 10 3,650 0.00 0 8.00 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 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) 48 17.520 0.00 0 14.00 15.00 ${\sf CAH}\ {\sf visits}$ 15.00 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 20.00 20.00 21.00 OTHER LONG TERM CARE 21.00 HOME HEALTH AGENCY 101.00 0 22.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 24.00 HOSPI CE 116.00 0 0 24.00 HOSPICE (non-distinct part) 30.00 24.10 24.10 25.00 CMHC - CMHC 25.00 RURAL HEALTH CLINIC 26.00 88.00 0 26.00 RURAL HEALTH CLINIC II 88.01 26 01 26 01 RURAL HEALTH CLINIC III 88.02 26.02

89.00

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28.00

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33.00

33.01

0 34.00

26.02

26. 25

27.00

28.00

29.00

30.00

31.00

32 00

32.01

33.01

FEDERALLY QUALIFIED HEALTH CENTER

Employee discount days (see instruction)

Labor & delivery days (see instructions)

Total ancillary labor & delivery room

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

outpatient days (see instructions)

Total (sum of lines 14-26)

Employee discount days - IRF

Observation Bed Days

Ambul ance Trips

33.00 LTCH non-covered days

Health Financial Systems HENRY COUNTY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-0030

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/26/2023 3:03 pm

		1 /0 0	(0 (0) (1)			5/26/2023 3:0	3 pm
		I /P Days	s / O/P Visits	/ Irips	Full lime	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component	TI LIE XVIII	II LIE XIX	Patients	& Residents	Payrol I	
		6. 00	7. 00	8.00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7.00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 446	202	6, 987			1.00
	8 exclude Swing Bed, Observation Bed and	2,	202	0,707			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	2, 845	1, 684				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation	2, 446	202	6, 987			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	505	0	1, 882			8.00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0				13.00
14.00	Total (see instructions)	2, 951	202	9, 389	0.00	468. 27	14.00
15.00	CAH visits	0	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						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	3, 350	1, 008	10, 901	0.00	14. 13	1
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE	0	0			5. 97	1
24. 10	HOSPICE (non-distinct part)			3			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	5, 437	1, 881	15, 972	0. 00	l e	1
26. 01	RURAL HEALTH CLINIC II	6, 941	7, 835			l e	
26. 02	RURAL HEALTH CLINIC III	1, 265	489	4, 119		l e	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)				0. 00	651. 39	27. 00
28. 00	Observation Bed Days		393	3, 253			28.00
29.00	Ambul ance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF		_	0			31.00
32. 00	Labor & delivery days (see instructions)	0	7	40			32.00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions)	0					33.00
	LTCH non-covered days LTCH site neutral days and discharges	0					33.00
	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00
34.00	Transporting Expansion Covid-17 The Acute Care	١	0	1	1	I	1 34.00

Provi der CCN: 15-0030

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/26/2023 3:03 pm

						5/26/2023 3:0	3 pm
		Full Time Equivalents		Di scha	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	659	41	2, 180	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)			620	424		2. 00
3. 00	HMO IPF Subprovider			020	424		3.00
4. 00	HMO IRF Subprovider				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF				o o		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	659	41	2, 180	14.00
15.00	CAH visits						15.00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE	0.00					21.00
22. 00 23. 00	HOME HEALTH AGENCY	0. 00					22. 00 23. 00
24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	0.00					24.00
24. 00	HOSPICE (non-distinct part)	0.00					24. 00
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26.00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 02	RURAL HEALTH CLINIC III	0.00					26. 02
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 Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care			l l			34.00

| Period: | Worksheet S-3 | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0030

					Ť	01/01/2022		
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	3 piii
		Number	Reported	ion of Salaries	Sal ari es (col. 2 ± col.	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col. 4	col . 5)	
		1. 00	2. 00	A-6) 3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
1. 00	SALARIES Total salaries (see	200. 00	58, 825, 014	0	58, 825, 014	1, 354, 820. 00	43. 42	1.00
1.00	instructions)	200.00	36, 623, 014	0	36, 623, 014	1, 354, 620. 00	43. 42	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0. 00	0. 00	2.00
3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0.00	3.00
4. 00	B Physician-Part A -		25 000	0	25 000	180. 00	120.00	4.00
4.00	Administrative		25, 000	0	25, 000	180.00	138. 89	4.00
4. 01	Physicians - Part A - Teaching		11 572 220	0	11 572 220	0.00	0.00	
5. 00	Physician and Non Physician-Part B		11, 573, 339	0	11, 573, 339	74, 300. 00	155. 76	5. 00
6. 00	Non-physician-Part B for		8, 129, 290	0	8, 129, 290	296, 105. 00	27. 45	6. 00
	hospi tal -based RHC and FQHC services							
7. 00	Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	0	0	0. 00	0. 00	7. 01
	residents (in an approved							
8. 00	programs) Home office and/or related		0	0	0	0. 00	0. 00	8. 00
9. 00	organization personnel SNF	44. 00	0		0	0. 00	0. 00	9. 00
10.00	Excluded area salaries (see	44.00	3, 647, 048	171, 422	3, 818, 470		36. 12	
	instructions)							
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		1, 283, 155	0	1, 283, 155	23, 423. 00	54. 78	11.00
12.00	Carte		0	0		0.00	0.00	12.00
12. 00	Contract Labor: Top Level management and other		U	0	0	0. 00	0.00	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		176, 019	0	176, 019	1, 409. 00	124. 92	13.00
14. 00	A - Administrative Home office and/or related		0	0	0	0. 00	0.00	14.00
14.00	organization salaries and		0	0		0.00	0.00	14.00
14. 01	wage-related costs Home office salaries		0	0	0	0. 00	0.00	14. 01
14. 02	Related organization salaries		0		ő			14. 02
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract		0	О	0	0. 00	0. 00	16. 00
16 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0. 00	0.00	16. 01
	- Teachi ng							
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 02
	WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		12, 607, 674	0	12, 607, 674			17. 00
18. 00	Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		1, 456, 985	0	1, 456, 985			19.00
20. 00	Non-physician anesthetist Part		0	Ō	0			20.00
21. 00	A Non-physician anesthetist Part		0	0	0			21.00
	В							
22. 00	Physician Part A - Administrative		4, 171	0	4, 171			22.00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		1, 804, 616 3, 719, 623		1, 804, 616 3, 719, 623			23. 00 24. 00
25. 00	Interns & residents (in an		0	Ō	0			25. 00
25. 50	approved program) Home office wage-related		0	n	n			25. 50
	(core)		_					
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A		0	0	0			25. 52
	- Administrative - wage-related (core)							
	' '	'		•	•	· '		·

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0030 Peri od: Worksheet S-3 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/26/2023 3:03 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 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 -929, 033 1, 293, 464 364, 431 9, 923. 00 36. 73 26.00 27.00 Administrative & General 5.00 8, 550, 342 -185, 085 8, 365, 257 147, 360. 00 56. 77 27.00 28. 00 253, 370 253, 370 867.00 292. 24 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 1, 574, 292 -34, 078 1, 540, 214 49, 204. 00 31. 30 30.00 Laundry & Linen Service 8.00 0.00 31.00 31.00 0.00 32.00 Housekeepi ng 9.00 0.00 0.00 32.00 33.00 Housekeeping under contract 939, 847 939, 847 45, 207. 00 20. 79 33.00 (see instructions) 34.00 Dietary 10.00 903, 130 -568, 027 335, 103 16, 116. 00 20.79 34.00 35.00 Dietary under contract (see \cap 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 273, 652 273, 652 13, 192. 00 20.74 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 0 Nursing Administration 2, 583, 043 48. 48 38.00 38.00 13.00 -31, 455 2 551 588 52, 630. 00 39.00 Central Services and Supply 14.00 284, 692 -6, 163 278, 529 14, 768.00 18.86 39.00 40.00 Pharmacy 15.00 0.00 0.00 40.00

759, 110

0

0

-16, 432

0

742, 678

0

0

30, 314. 00

0.00

0.00

24.50 41.00

0.00 42.00

0.00 43.00

16.00

17.00

18.00

Medical Records & Medical Records Library

Social Service

43.00 Other General Service

41.00

42.00

HOSPI 1	FAL WAGE INDEX INFORMATION			Provi der C		Period: From 01/01/2022 To 12/31/2022		pared:
		Worksheet A	Amount	Recl assi fi cat	Adjusted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			·	Sal ari es	(col.2 ± col.	Sal ari es 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						l
1.00	Net salaries (see		40, 315, 602	0	40, 315, 60	2 1, 030, 489. 00	39. 12	1.00
	instructions)							l
2.00	Excluded area salaries (see		3, 647, 048	171, 422	3, 818, 47	0 105, 712. 00	36. 12	2.00
	instructions)							l
3.00	Subtotal salaries (line 1		36, 668, 554	-171, 422	36, 497, 13	2 924, 777. 00	39. 47	3.00
	minus line 2)							l
4. 00	Subtotal other wages & related		1, 459, 174	0	1, 459, 17	4 24, 832. 00	58. 76	4. 00
	costs (see inst.)							l
5.00	Subtotal wage-related costs		12, 611, 845	0	12, 611, 84	5 0.00	34. 56	5.00
	(see inst.)							l
6. 00	Total (sum of lines 3 thru 5)		50, 739, 573	1				
7.00	Total overhead cost (see		14, 918, 793	725, 876	15, 644, 66	9 379, 581. 00	41. 22	7. 00
7.00	Total Overhead Cost (see		14, 910, 793	123, 670	15, 644, 66	3/9, 301.00	41.22	7.0

instructions)

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

	10 12/31/2022	5/26/2023 3:0	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 521, 975	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	o	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	o	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	o	6.00
7.00	Employee Managed Care Program Administration Fees	o	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	11, 260, 289	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	131, 724	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	538, 582	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)	837, 899	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	351, 454	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumulative portion)		
	TAXES		l
17. 00	FICA-Employers Portion Only	3, 914, 349	
18. 00	Medicare Taxes - Employers Portion Only	0	18.00
19. 00	Unempl oyment Insurance	1, 873	
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00		0	21.00
	instructions))		ı
22. 00		0	
	Tuition Reimbursement	34, 923	
24. 00		19, 593, 068	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	ļ	25. 00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part V | To | 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0030

			5/26/2023 3:0	3 pm
	Cost Center Description	Contract	Benefit Cost	
		Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1. 00	Total facility's contract labor and benefit cost	1, 283, 155		
2.00	Hospi tal	1, 283, 155	19, 593, 068	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			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14. 01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14. 02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18. 00	Other	0	0	18. 00

Heal th	n Financial Systems HE	ENRY COUNTY MEM	IORIAL HOSPITAL		In Li∈	eu of Form CMS-:	2552-10
HOME I	HEALTH AGENCY STATISTICAL DATA		Provi der C		Period: From 01/01/2022		
			Component	CCN: 15-7430	Го 12/31/2022	Date/Time Pre 5/26/2023 3:0	
					Home Health Agency I	PPS	
0. 00	County				1.	00	0.00
		Ti tle V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00		1	0.00	1	1. 00 2. 00
2. 00	Tollador Foured Solisus South (See Thistractions)	0.00	100.00		loyees (Full Ti		2.00
		Enter the numb	er of hours in	Staff	Contract	Total	
			work week	Starr	Contract	Total	
			1	1 00	2.00	2.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES)	1.00	2.00	3.00	
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40. 00	0. 00 2. 7!		•	1
5.00	Other Administrative Personnel			1. 30	0.00	1. 36	5.00
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			9. 73		•	1
8.00	Physical Therapy Service			4. 65	0.00	4. 65	8. 00
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0. 00 0. 1			9. 00 10. 00
11. 00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12. 00 13. 00	1 33			0. 00		1	1
14. 00	Medical Social Service			0.00	0.00	0.00	14.00
15. 00 16. 00	·			0.00		1	
17. 00	Home Health Aide Supervisor			0.00	0.00	0.00	17. 00
18.00	Other (specify)			0.00	0.00	0.00 CBSA Data	18.00
	HOME HEALTH AGENCY CBSA CODES					1.00	
	Enter in column 1 the number of CBSAs where					3	19. 00
20. 00	List those CBSA code(s) in column 1 serviced first code).	I during this c	ost reporting	period (line 2	0 contains the	17140	20.00
20. 01 20. 02						34620 99915	20. 01 20. 02
20.02			oi sodes				20.02
		Without Outliers	With Outliers	LUPA Epi sodes	PEP Only Epi sodes	Total (cols. 1-4)	
	PPS ACTIVITY DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	773				1, 072	21.00
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	284, 980 1, 050				395, 600 1, 359	
24.00	Physical Therapy Visit Charges	387, 714		1			24.00
25. 00 26. 00	1	40 14, 396	ł .	1	2 C 3 C	242 88, 462	
27. 00	Speech Pathology Visits	1	31		0	32	27. 00
28. 00 29. 00		374	11, 594 0	l .		,	28. 00 29. 00
30.00	Medical Social Service Visit Charges	0	0		0	0	30.00
31. 00 32. 00		381 65, 723	262 45, 314	1) 2) 334	1	
33. 00	· · · · · · · · · · · · · · · · · · ·	2, 245	1, 056	3.	1 18	3, 350	33.00
34. 00		0					34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	753, 187	339, 180	11, 450	6, 264	1, 110, 087	35.00
36. 00	Total Number of Episodes (standard/non	200		14	4 2	216	36. 00
37. 00	outlier) Total Number of Outlier Episodes		49		C		
38. 00	Total Non-Routine Medical Supply Charges	5, 426	9, 748	(374	15, 548	38.00

inic Address and Identification treet ty, State, ZIP Code, County DSPITAL-BASED FOHCS ONLY: Designation - Enter urce of Federal Funds Dimmunity Health Center (Section 330(d), PHS grant Health Center (Section 329(d), PHS Act and the Services for the Homeless (Section 340 pok-Alikes THER (SPECIFY) Des this facility operate as other than a home and the second of	Act) ct) O(d), PHS Act) ospi tal -based	Component Ci 1. NEW CASTLE	Gran	2200 FOREST RI State 2.00	2 Date/Time Pr 5/26/2023 3: Cost	repare : 03 pr
ty, State, ZIP Code, County DSPITAL-BASED FQHCs ONLY: Designation - Enter Durce of Federal Funds Domining the Health Center (Section 330(d), PHS grant Health Center (Section 329(d), PHS Act and the Services for the Homeless (Section 340 populachian Regional Commission pook-Alikes THER (SPECIFY) Does this facility operate as other than a holes or "N" for no in column 1. If yes, indicate	Act) ct) O(d), PHS Act) ospi tal -based	Ci 1. NEW CASTLE	ty 00 urban Grai	To	2 Date/Time P 5/26/2023 3: Cost .00 IDGE PARKWAY ZIP Code 3.00 V47362	1 1 2 2 0 3 A 5 6 6 7 8
ty, State, ZIP Code, County DSPITAL-BASED FQHCs ONLY: Designation - Enter Durce of Federal Funds Domining the Health Center (Section 330(d), PHS grant Health Center (Section 329(d), PHS Act and the Services for the Homeless (Section 340 populachian Regional Commission pook-Alikes THER (SPECIFY) Does this facility operate as other than a holes or "N" for no in column 1. If yes, indicate	Act) ct) O(d), PHS Act) ospi tal -based	1. NEW CASTLE	urban Grai	2200 FOREST RI State 2.00	Cost DGE PARKWAY ZIP Code 3.00 N47362 1.00 Date	1 1 2 2 0 3 4 5 6 6 7 8
ty, State, ZIP Code, County DSPITAL-BASED FQHCs ONLY: Designation - Enter Durce of Federal Funds Domining the Health Center (Section 330(d), PHS grant Health Center (Section 329(d), PHS Act and the Services for the Homeless (Section 340 populachian Regional Commission pook-Alikes THER (SPECIFY) Does this facility operate as other than a holes or "N" for no in column 1. If yes, indicate	Act) ct) O(d), PHS Act) ospi tal -based	1. NEW CASTLE	urban Grai	2200 FOREST RI State 2.00	.00 I DGE PARKWAY ZIP Code 3.00 V47362 1.00 Date	0 3
ty, State, ZIP Code, County DSPITAL-BASED FQHCs ONLY: Designation - Enter Durce of Federal Funds Domining the Health Center (Section 330(d), PHS grant Health Center (Section 329(d), PHS Act and the Services for the Homeless (Section 340 populachian Regional Commission pook-Alikes THER (SPECIFY) Does this facility operate as other than a holes or "N" for no in column 1. If yes, indicate	Act) ct) O(d), PHS Act) ospi tal -based	1. NEW CASTLE	urban Grai	2200 FOREST RI State 2.00	ZIP Code 3.00 V47362 1.00 Date	0 3
ty, State, ZIP Code, County DSPITAL-BASED FQHCs ONLY: Designation - Enter Durce of Federal Funds Domining the Health Center (Section 330(d), PHS grant Health Center (Section 329(d), PHS Act and the Services for the Homeless (Section 340 populachian Regional Commission pook-Alikes THER (SPECIFY) Does this facility operate as other than a holes or "N" for no in column 1. If yes, indicate	Act) ct) O(d), PHS Act) ospi tal -based	1. NEW CASTLE	urban Grai	State 2.00	ZIP Code 3.00 V47362 1.00	0 3
ty, State, ZIP Code, County OSPITAL-BASED FOHCS ONLY: Designation - Enter Ource of Federal Funds Ommunity Health Center (Section 330(d), PHS grant Health Center (Section 329(d), PHS Ac ealth Services for the Homeless (Section 340 opalachian Regional Commission ook-Alikes THER (SPECIFY) oes this facility operate as other than a holes or "N" for no in column 1. If yes, indica	Act) ct) O(d), PHS Act) ospi tal -based	1. NEW CASTLE	urban Grai	State 2.00	ZIP Code 3.00 V47362 1.00	0 3
USPITAL-BASED FOHCS ONLY: Designation - Enter Durce of Federal Funds Dommunity Health Center (Section 330(d), PHS Grant Health Center (Section 329(d), PHS Act Bealth Services for the Homeless (Section 340 Dopalachian Regional Commission DOK-Alikes THER (SPECIFY) Does this facility operate as other than a holes or "N" for no in column 1. If yes, indica	Act) ct) O(d), PHS Act) ospi tal -based	1. NEW CASTLE	urban Grai	2.00	3.00 V 47362 1.00 Date	0 3 4 5 6 7 8
USPITAL-BASED FOHCS ONLY: Designation - Enter Durce of Federal Funds Dommunity Health Center (Section 330(d), PHS Grant Health Center (Section 329(d), PHS Act Bealth Services for the Homeless (Section 340 Dopalachian Regional Commission DOK-Alikes THER (SPECIFY) Does this facility operate as other than a holes or "N" for no in column 1. If yes, indica	Act) ct) O(d), PHS Act) ospi tal -based	NEW CASTLE	urban Grai	nt Award	1.00 Date	0 3 4 5 6 7 8
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umber of total visits for this provider.						
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Health Financial Systems HE	ENRY COUNTY MEM	ORIAL HOSPITAL	=	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	
				From 01/01/2022		
		Component	CCN: 15-8520	To 12/31/2022	Date/Time Pre	pared:
		·			5/26/2023 3:0	3 pm
				RHC I	Cost	
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	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11.00

	n Financial Systems HE	ENRY COUNTY MEM	IORI AL HOSPI TAL	_	In Lie	eu of Form CMS	5-2552
	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0030	Peri od:	Worksheet S	-8
			Component	CCN: 15-8525	From 01/01/2022 To 12/31/2022	2 Date/Time P	
					RHC II	5/26/2023 3: Cost	
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	Clinic Address and Identification						
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				00	State 2.00	ZI P Code 3. 00	
2. 00	City, State, ZIP Code, County		NEW CASTLE	00		N 47362	2
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						1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for			Data	0 3
					nt Award 1.00	2. 00	
	Source of Federal Funds				1.00	2.00	
4. 00	Community Health Center (Section 330(d), PHS	Act)		T			4
5. 00	Migrant Health Center (Section 329(d), PHS A	ct)					5
5. 00	Health Services for the Homeless (Section 34	O(d), PHS Act)					6
7. 00	Appal achi an Regi onal Commi ssi on						7
3. 00 9. 00	Look-Alikes OTHER (SPECIFY)						8
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	yes or "N" for no in column 1. If yes, indic						
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	Facility hours of operations (1)		ı	T			
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					1. 00	2. 00	+
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13.00	Is this a consolidated cost report as define				N		0 10
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	30.8? Enter "Y" for yes or "N" for no in col						0 13
	number of providers included in this report.						0 13
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Health Financial Systems HE	ENRY COUNTY MEM	ORIAL HOSPITAL	=	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0030	Peri od:	Worksheet S-8	
				From 01/01/2022		
		Component	CCN: 15-8525	To 12/31/2022	Date/Time Pre	pared:
		·			5/26/2023 3:0	3 pm
				RHC II	Cost	
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	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 30	17: 00				11.00

alth Financial Systems I SPITAL-BASED RHC/FOHC STATISTICAL DATA	HENRY COUNTY MEN		CN: 15-0030	Peri od:	ieu of Form Cl Worksheet	
				From 01/01/202	22	
		Component	CCN: 15-8556	To 12/31/202	22 Date/Ti me 5/26/2023	
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Clinic Address and Identification					1.00	
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			ty	State	ZIP Code	
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O HOSPITAL-BASED FOHCS ONLY: Designation - Er	nter "R" for rur	al or "U" for		t Award	Date	0 3
				1. 00	2.00	
Source of Federal Funds						
O Community Health Center (Section 330(d), Ph						4
<pre>0 Migrant Health Center (Section 329(d), PHS 0 Health Services for the Homeless (Section 3</pre>						5
O Appalachian Regional Commission	5.15(a), 1115 ACL)					7
0 Look-Alikes						8
0 OTHER (SPECIFY)						9
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Facility hours of operations (1) CLINIC Have you received an approval for an except Is this a consolidated cost report as defir 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no i column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	from 1.00 tion to the produced in CMS Pub. blumn 1. If yes, t. List the name Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi	from 3.00 08:00 ard? r 9, section mn 2 the ders and Provi	19: 00 19: 00 1. 00 Y N der name	68: 00 08: 00 2. 00 CCN 2. 00	0 13 14 ts
Facility hours of operations (1) CLINIC Have you received an approval for an except 1s this a consolidated cost report as defir 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no i column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	from 1.00 tion to the produced in CMS Pub. blumn 1. If yes, t. List the name Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi	from 3.00 08:00 ard? r 9, section mn 2 the ders and Provi XVIII 3.00	19: 00 19: 00 1. 00 Y N der name	68: 00 08: 00 2. 00 CCN 2. 00	0 13 14 ts
Facility hours of operations (1) OO CLINIC OO Have you received an approval for an except 1s this a consolidated cost report as defir 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report numbers below. OO RHC/FQHC name, CCN OO Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	from 1.00 tion to the produced in CMS Pub. blumn 1. If yes, t. List the name Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi	from 3.00 08:00 ard? r 9, section mn 2 the ders and Provi XVIII 3.00	19: 00 19: 00 1. 00 Y N der name	68: 00 08: 00 2. 00 CCN 2. 00	0 13 14 ts
Facility hours of operations (1) CLINIC Have you received an approval for an except 1s this a consolidated cost report as defir 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no i column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	from 1.00 tion to the produced in CMS Pub. blumn 1. If yes, t. List the name Y/N 1.00	to 2.00 uctivity stand 100-04, chapte enter in colus s of all provi V 2.00	from 3.00 08:00 ard? r 9, section mn 2 the ders and Provi XVIII 3.00	19: 00 19: 00 1. 00 Y N der name	68: 00 08: 00 2. 00 CCN 2. 00	0 13 14 ts 15
Facility hours of operations (1) CLINIC Have you received an approval for an except 1s this a consolidated cost report as defir 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no i column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	from 1.00 tion to the produced in CMS Pub. blumn 1. If yes, t. List the name Y/N 1.00	to 2.00 uctivity stand 100-04, chapte enter in colu s of all provi V 2.00 Cou	from 3.00 08:00 ard? r 9, section mn 2 the ders and Provi XVIII 3.00	to 4.00	68: 00 08: 00 2. 00 CCN 2. 00	0 13 14 ts
Facility hours of operations (1) CLINIC Have you received an approval for an except 1s this a consolidated cost report as defir 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no i column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	from 1.00 tion to the produced in CMS Pub. Diumn 1. If yes, t. List the name Y/N 1.00	to 2.00 uctivity stand 100-04, chapte enter in colu s of all provi V 2.00 Cou	from 3.00 08:00 ard? r 9, section mn 2 the ders and Provi XVIII 3.00	to 4.00	From 5. 00	0 13 14 ts 15

Health Financial Systems HE	ENRY COUNTY MEM	ORI AL HOSPITAL	=	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	
				From 01/01/2022		
		Component	CCN: 15-8556	To 12/31/2022		
					5/26/2023 3:0	3 pm
				RHC III	Cost	
	Fri	day	Sat	urday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	19: 00	08: 00	12: 00		11.00

HOSPI 7	ı Financial Systems FAL-BASED HOSPICE IDENTIFICATION	DATA				Period: From 01/01/2022 To 12/31/2022		IGH IV pared:
						Hospi ce I	0, 20, 2020 0.0	<u> </u>
		Undupl i cated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING	PERIODS BEGINN	ING BEFORE OCTO	DBER 1, 2015			
1. 00	Hospice Continuous Home Care							1.00
2. 00	Hospice Routine Home Care							2.00
3. 00	Hospice Inpatient Respite Care							3.00
4. 00	Hospice General Inpatient Care							4.00
5. 00	Total Hospice Days	DEDODEL NO DED		DEFORE COTORE				5.00
,	Part II - CENSUS DATA FOR COST	REPORTING PER	ODS BEGINNING	BEFORE OCTOBER	₹ 1, 2015			
6. 00	Number of patients receiving							6.00
7 00	hospice care Total number of unduplicated							7 00
7. 00	Continuous Care hours billable							7.00
	to Medicare							
8. 00	Average Length of Stay (line 5							8.00
0.00	/ line 6)							0.00
9. 00	Unduplicated census count							9.00
	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			7.00
	,			Title XVIII	Title XIX	Other	Total (sum of	
				II LIE AVIII	l little xix	Other	col s. 1	
							through 3)	
				1.00	2, 00	3.00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERIODS BEGI					
10.00	Hospi ce Conti nuous Home Care			0		0 0	0	10.00
11. 00	Hospice Routine Home Care			4, 521		7 169	4, 697	11.00
12. 00	Hospice Inpatient Respite Care			38		0 6	44	12.00
13. 00	Hospice General Inpatient Care			3		6 1	10	13.00
14. 00	Total Hospi ce Days			4, 562		13 176	4, 751	14.00
	PART IV - CONTRACTED STATISTICA	AL DATA FOR CO	ST REPORTING P	ERIODS BEGINNIN	NG ON OR AFTE	ER OCTOBER 1, 201	15	
15. 00	Hospice Inpatient Respite Care			0		0 0	0	15.00
	Hospice General Inpatient Care			0		0 0		16.00

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL		u of Form CMS-2	2552-TO					
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA Provider CCN: 15-0030 Perio	od:	Worksheet S-1						
From To	01/01/2022 12/31/2022	Date/Time Pre	narod:					
	12/31/2022	5/26/2023 3: 0						
		1.00						
Uncompensated and indigent care cost computation		1.00						
1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0. 296843	1.00					
Medicaid (see instructions for each line) 2.00 Net revenue from Medicaid		3, 358, 466	2.00					
3.00 Did you receive DSH or supplemental payments from Medicaid?		γ 3, 336, 400	3.00					
4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Ϋ́	4.00					
5.00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00					
6.00 Medicaid charges		56, 721, 203						
7.00 Medicaid cost (line 1 times line 6)		16, 837, 292	1					
8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 < zero then enter zero)	2 and 5; if	13, 478, 826	8. 00					
Children's Health Insurance Program (CHIP) (see instructions for each line)								
9.00 Net revenue from stand-al one CHIP		0	9.00					
10.00 Stand-alone CHIP charges		0	10.00					
11.00 Stand-alone CHIP cost (line 1 times line 10)		0						
12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if <	zero then	0	12.00					
enter zero) Other state or local government indigent care program (see instructions for each line)								
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00					
14.00 Charges for patients covered under state or local indigent care program (Not included in I	lines 6 or	Ö	•					
10)								
15.00 State or local indigent care program cost (line 1 times line 14)		0						
16.00 Difference between net revenue and costs for state or local indigent care program (line 15	5 minus line	0	16. 00					
13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent	care progra	l ams (see						
instructions for each line)	care progra							
17.00 Private grants, donations, or endowment income restricted to funding charity care		0						
18.00 Government grants, appropriations or transfers for support of hospital operations	6.11	0	18.00					
19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (su 8, 12 and 16)	um of lines	13, 478, 826	19.00					
Uni nsured	Insured	Total (col. 1						
	pati ents	+ col . 2)						
Uncompensated Care (see instructions for each line)	2. 00	3. 00						
20.00 Charity care charges and uninsured discounts for the entire facility 2, 354, 721	970, 928	3, 325, 649	20.00					
(see instructions)								
21.00 Cost of patients approved for charity care and uninsured discounts (see 698, 982	970, 928	1, 669, 910	21. 00					
instructions) 22.00 Payments received from patients for amounts previously written off as	0	0	22. 00					
chari ty care	070 000	1 //0 010	00.00					
23.00 Cost of charity care (line 21 minus line 22) 698,982	970, 928	1, 669, 910	23.00					
		1. 00						
24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of s	stay limit	N	24.00					
imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's I	length of	0	25. 00					
stay limit		7 522 020	24 00					
26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions)		7, 522, 938 111, 647	1					
27.00 Medicare allowable bad debts for the entire hospital complex (see instructions)		171, 765	1					
28.00 Non-Medicare bad debt expense (see instructions)		7, 351, 173	1					
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2, 242, 262	29. 00					
30.00 Cost of uncompensated care (line 23 column 3 plus line 29)		3, 912, 172						
Total unreimbursed and uncompensated care cost (line 19 plus line 30) 17, 390, 998 31.00								

Heal th Fi	nancial Systems HE	NRY COUNTY MEMOI	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSI F	FICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der Co		eri od:	Worksheet A	
					rom 01/01/2022 o 12/31/2022	Date/Time Pre	nared:
				'	0 12/31/2022	5/26/2023 3:0	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cat	Reclassi fied	
				+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +- col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	NERAL SERVICE COST CENTERS						
	100 NEW CAP REL COSTS-BLDG & FIXT		5, 600, 516			5, 511, 622	1.00
	200 NEW CAP REL COSTS-MVBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT	-929, 033	0 13, 060, 044	C 12, 131, 011	,	411, 326 17, 125, 516	
	500 ADMINISTRATIVE & GENERAL	8, 550, 342	13, 403, 624			21, 768, 881	5.00
	700 OPERATION OF PLANT	1, 574, 292	2, 108, 391			3, 648, 605	
	800 LAUNDRY & LINEN SERVICE	0	458, 396			458, 396	
	900 HOUSEKEEPI NG	003 130	1, 022, 443			1, 022, 443	
	000 DI ETARY 100 CAFETERI A	903, 130	620, 164	1, 523, 294	-953, 153 465, 884	570, 141 465, 884	
	300 NURSI NG ADMI NI STRATI ON	2, 583, 043	359, 854	2, 942, 897		2, 911, 442	
	400 CENTRAL SERVICES & SUPPLY	284, 692	280, 055			558, 584	
	500 PHARMACY	0	5, 395, 425			5, 183, 366	
	600 MEDI CAL RECORDS & LI BRARY	759, 110	193, 833	952, 943	-16, 432	936, 511	16.00
	PATIENT ROUTINE SERVICE COST CENTERS 000 ADULTS & PEDIATRICS	7, 391, 097	3, 110, 889	10, 501, 986	-1, 130, 492	9, 371, 494	30.00
	100 INTENSIVE CARE UNIT	1, 640, 334	1, 813, 013			3, 417, 840	
43. 00 04	300 NURSERY	0	0	C		668, 057	
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	6, 028, 409	12, 739, 317			7, 635, 532	1
	200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-DIAGNOSTIC	0 2, 117, 377	0 1, 064, 950	C 3, 182, 327		204, 272 2, 813, 185	
	700 CT SCAN	183, 581	1, 128, 594			1, 308, 201	
	800 MAGNETIC RESONANCE IMAGING (MRI)	149, 056	485, 922			631, 752	
	900 CARDIAC CATHETERIZATION	0	0	C	0	0	59.00
	000 LABORATORY	2, 152, 192	3, 765, 076	5, 917, 268	-46, 587	5, 870, 681	
	001 BLOOD LABORATORY 500 RESPI RATORY THERAPY	927, 447	935, 402	1, 862, 849	-22, 534	1, 840, 315	60. 01 65. 00
	600 PHYSI CAL THERAPY	1, 326, 237	1, 009, 457			2, 306, 986	1
	700 OCCUPATI ONAL THERAPY	232, 261	18, 840			246, 073	
	800 SPEECH PATHOLOGY	91, 898	6, 990			96, 899	1
	900 ELECTROCARDI OLOGY	202, 213	179, 280			377, 116	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENT	0	-482, 264	-482, 264 C		384, 675 9, 721, 825	
	300 DRUGS CHARGED TO PATIENTS	o	0		0	9, 721, 029	73.00
76. 00 03	950 CARDI AC REHAB	194, 575	23, 252	217, 827	-4, 211	213, 616	76. 00
	TPATIENT SERVICE COST CENTERS						
	800 RURAL HEALTH CLINIC 801 RURAL HEALTH CLINIC II	4, 996, 057 9, 636, 801	2, 373, 103 4, 552, 299			6, 089, 822 12, 341, 355	
	802 RURAL HEALTH CLINIC III	1, 053, 313	604, 530			1, 478, 838	
	100 EMERGENCY	3, 129, 542	2, 024, 599			5, 086, 397	
92. 00 09:	200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
0TI	HER REIMBURSABLE COST CENTERS	4 050 000	0/4 000	1 504 440	44 005	4 400 447	101 00
101.00 10	100 HOME HEALTH AGENCY ECLAL PURPOSE COST CENTERS	1, 259, 339	264, 803	1, 524, 142	-41, 025	1, 483, 117	1101.00
	300 INTEREST EXPENSE		0	С	0	0	113.00
	400 UTILIZATION REVIEW-SNF	0	0	C	0		114.00
	600 HOSPI CE	534, 157	404, 180			920, 978	
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NREIMBURSABLE COST CENTERS	56, 971, 462	78, 524, 977	135, 496, 439	-414, 696	135, 081, 743]118. 00
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0		ol ol	0	190. 00
	200 PHYSI CI ANS' PRI VATE OFFI CES	1, 676, 090	617, 480	2, 293, 570	-136, 125	2, 157, 445	
	950 HOSPI TALI ST	0	0	C	o		194. 00
	951 RENTAL	0	0	010 503	88, 894	88, 894	1
	955 OTHER NONREIMBURSABLE COSTS 956 DR AFZAL	0	219, 597 7, 567	219, 597 7, 567		219, 597 7, 567	194.05
	957 PHILLIPS HALL	o	7, 307	7,307			194.07
	958 OB DRS	O	0	C	o		194. 08
	959 THE WATERS	0	0	C	467, 720	467, 720	
	960 CAMBRIDGE CITY	0	0	0	0		194. 10
	961 WELL BEING 962 ACTIVATE HEALTH EMPLOYER CLINIC	0	393 64, 711	393 64, 711			194. 11 194. 12
	963 NEW CASTLE PEDIATRICS	o o	0	54, , 11	ol ol		194. 12
194. 14 07	964 HENRY COUNTY RADIOLOGY	177, 462	1, 777, 679	1, 955, 141	-5, 793	1, 949, 348	194. 14
	965 HENRY COUNTY ANESTHESI OLOGY	0	0	C	0		194. 15
194. 16 07 ⁹ 200. 00	966 NEW CASTLE IMMEDICATE CARE & FAMILY TOTAL (SUM OF LINES 118 through 199)	0 58, 825, 014	0 81, 212, 404	0 140, 037, 418	0 0		194. 16
200.00	TOTAL (SOM OF LINES THE UNIOUGH 199)	50, 025, 014	01, 212, 404	1 140,007,410	, Y	140, 007, 410	₁ 200.00

Provi der CCN: 15-0030

Peri od: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/26/2023 3:03 pm

			''	0 12/31/2022	5/26/2023 3:03	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
	4.00	Allocation	-			
GENERAL SERVICE COST CENTERS	6. 00	7. 00				
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT	-177, 004	5, 334, 618	1			1. 00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP	0	411, 326				2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	3, 084, 415	20, 209, 931				4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	-5, 122, 295	16, 646, 586	1			5.00
7. 00 00700 OPERATION OF PLANT	0	3, 648, 605	1			7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	458, 396 1, 022, 443	1			8. 00 9. 00
10. 00 01000 DI ETARY	-20, 835	549, 306	1			9.00
11. 00 01100 CAFETERI A	-265, 404	200, 480	1			1.00
13.00 01300 NURSING ADMINISTRATION	94, 835	3, 006, 277	1		1	3.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	558, 584				4.00
15. 00 01500 PHARMACY	-875, 427	4, 307, 939	1			5.00
16. 00 O1600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	-35, 019	901, 492			I	6. 00
30. 00 O3000 ADULTS & PEDIATRICS	-2, 576, 042	6, 795, 452	,		3	30. 00
31. 00 03100 NTENSI VE CARE UNI T	2, 370, 042	3, 417, 840	1			31. 00
43. 00 04300 NURSERY	0	668, 057	1			13.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	-3, 342, 684	4, 292, 848	1			0.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	204, 272				2.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	-2, 848 -726, 485	2, 810, 337 581, 716	1			54. 00 57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	-311, 176	320, 576	1			8. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1			9. 00
60. 00 06000 LABORATORY	-29, 783	5, 840, 898			6	60.00
60. 01 06001 BLOOD LABORATORY	0	0	1			60. 01
65. 00 06500 RESPIRATORY THERAPY	25, 002	1, 865, 317	1			5.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	-722, 744	1, 584, 242 246, 073	1			66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	0	96, 899	1			8. 00
69. 00 06900 ELECTROCARDI OLOGY	ő	377, 116	1			9. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	384, 675	1			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	9, 721, 825	5			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	1			73.00
76. 00 03950 CARDI AC REHAB	0	213, 616)			76. 00
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	-390, 753	5, 699, 069)		8	38. 00
88. 01 08801 RURAL HEALTH CLINIC II	-2, 202, 021	10, 139, 334	1			38. 01
88.02 08802 RURAL HEALTH CLINIC III	-117, 545	1, 361, 293	1			38. 02
91. 00 09100 EMERGENCY	-38, 058	5, 048, 339			9	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					9	92.00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	12 001	1 471 007			10	1 00
SPECIAL PURPOSE COST CENTERS	-12, 091	1, 471, 026)		10	01.00
113. 00 11300 I NTEREST EXPENSE	0	0			11	3. 00
114. 00 11400 UTILIZATION REVIEW-SNF	0	0	•			4. 00
116. 00 11600 H0SPI CE	-12, 095	908, 883				6.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-13, 776, 057	121, 305, 686			11	8.00
NONREI MBURSABLE COST CENTERS		0	J		10	00.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0 -89, 863	2 067 592				90. 00 92. 00
194. 00 07950 HOSPI TALI ST	-69, 603	2, 067, 582 0	1			94.00
194. 01 07951 RENTAL	ő	88, 894	1			94. 01
194.05 07955 OTHER NONREIMBURSABLE COSTS	0	219, 597				94. 05
194. 06 07956 DR AFZAL	0	7, 567	'			94.06
194. 07 07957 PHI LLI PS HALL	0	0	1			94. 07
194.08 07958 0B DRS 194.09 07959 THE WATERS	0	0 467 720	1			94. 08 94. 09
194. 10 07959 THE WATERS 194. 10 07960 CAMBRI DGE CITY	0	467, 720 0	1			94. 09 94. 10
194. 11 07961 WELL BEING		393				94. 11
194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC	Ö	64, 711	1			94. 12
194. 13 07963 NEW CASTLE PEDIATRICS	O	0				94. 13
194. 14 07964 HENRY COUNTY RADI OLOGY	0	1, 949, 348				94. 14
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY	0	0	2			94. 15
194.16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY 200.00 TOTAL (SUM OF LINES 118 through 199)	-13 865 920	126 171 400				94. 16 00. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-13, 865, 920	126, 171, 498	'I		20	JU. UU

| Period: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0030

					To 12/31/2022 Date/Tin	me Prepared: 23 3:03 pm
		Increases		0.11	0,20,202	
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00		
	A - OB/NURSERY/L&D					
1. 00 2. 00	NURSERY DELIVERY ROOM & LABOR ROOM	43. 00 52. 00	602, 529 184, 235	78, 571 24, 025		1. 00 2. 00
2.00	0		786, 764	102, 596		2.00
	B - CAFETERIA					
1. 00	CAFETERI A		<u>279, 7</u> 06 279, 706	19 <u>2, 2</u> 32 192, 232		1.00
	C - WATERS EXCLUSIONS		217, 100	172, 232		
1.00	THE WATERS	194. 09	280, 907	192, 894		1.00
	D - DEPRECIATION POB		280, 907	192, 894		
1. 00	RENTAL	194. 01	0	88, 894		1.00
	0			88, 894		
1. 00	E - EQUI PMENT RENTAL NEW CAP REL COSTS-MVBLE	2. 00	O	411, 326		1.00
1.00	EQUI P	2.00	٩	411, 320		1.00
2.00		0. 00	O	0		2. 00
3. 00 4. 00		0. 00 0. 00	0	0		3. 00 4. 00
4.00				411, 326		4.00
	F - IMPLANTABLE DEVICES					
1. 00	I MPL. DEV. CHARGED TO PATIENT	72. 00	0	9, 721, 825		1.00
	0			9, 721, 825		
	G - BONUS RECLASS					
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 0. 00	1, 301, 527 0	0		1. 00 2. 00
3. 00		0. 00	Ö	0		3. 00
4.00		0. 00	О	0		4. 00
5. 00		0.00	0	0		5.00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0. 00	ō	0		8. 00
9.00		0.00	0	0		9.00
10. 00 11. 00		0. 00 0. 00	0	0		10.00 11.00
12. 00		0. 00	Ö	Ö		12.00
13.00		0. 00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0. 00	ol Ol	0		16.00
17. 00		0. 00	0	0		17. 00
18.00		0.00	0	0		18.00
19. 00 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
21. 00		0. 00	Ö	Ö		21.00
22.00		0.00	0	0		22. 00
23. 00 24. 00		0. 00 0. 00	0	0		23. 00 24. 00
25. 00		0. 00	Ö	Ö		25. 00
26. 00		0. 00	O	0		26.00
27. 00 28. 00		0. 00 0. 00	0	0		27. 00 28. 00
29. 00		0.00	o	0		29.00
30.00		0. 00	О	0		30.00
31.00		0.00	0	0		31. 00 32. 00
32. 00		0.00		0		32.00
	I - MEDICAL DIRECTOR RECLASS					
1. 00	NURSI NG ADMI NI STRATI ON	1300	25, 000	0		1. 00
	U - MED SUPPLIES RECLASS		25, 000	U		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	10, 588, 764		1.00
	PATI ENTS					
	O M - FOREST RIDGE STAFF RECLASS	<u> </u>	0	10, 588, 764		
1. 00	RURAL HEALTH CLINIC II	88. 01	137, 608	0		1.00
50	0		137, 608	0		
1 00	0 - BENEFIT RECLASS			2 704 211		
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 0. 00	0	3, 701, 041 0		1. 00 2. 00
3. 00		0.00	o	0		3.00
4.00		0.00	0	0		4.00
5. 00		0. 00	0	0		5.00

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL RECLASSIFICATIONS Provider CCN: 15-0030

Peri od: Worksheet A-6 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

In Lieu of Form CMS-2552-10

					10	Date/ IT lie IT	epai eu.
						5/26/2023 3:0	03 pm
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
6.00		0.00	0	0			6.00
7.00		0.00	0	0			7.00
8.00		0.00	0	0			8.00
9.00		0.00	0	0			9.00
10.00		0.00	0	0			10.00
	0		0	3, 701, 041			
500.00	Grand Total: Increases		2, 811, 512	24, 999, 572			500.00

RECLASSI FI CATI ONS

Provider CCN: 15-0030

Peri od: Worksheet A-6 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

5/26/2023 3:03 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - OB/NURSERY/L&D ADULTS & PEDIATRICS 1.00 30.00 786, 764 102, 596 0 1.00 0 2.00 2.00 0.00 102, 596 786, 764 B - CAFETERIA 1.00 DI ETARY 10.00 279, 706 192, 232 0 1.00 279, 706 192, 232 C - WATERS EXCLUSIONS 1.00 DI ETARY 10.00 280, 907 192, 894 0 1.00 280, 907 192, 894 D - DEPRECIATION POB 1.00 NEW CAP REL COSTS-BLDG & 1.00 0 88, 894 1.00 ō 88, 894 - EQUIPMENT RENTAL 1 00 ADULTS & PEDIATRICS 30.00 0 78.078 1.00 2.00 OPERATING ROOM 50.00 0 7, 482 0 2.00 RADI OLOGY-DI AGNOSTI C 54.00 0 3.00 323, 308 0 3.00 <u>2, 4</u>58 <u>65.</u>00 4.00 RESPIRATORY THERAPY 4.00 0 ō 411, 326 F - IMPLANTABLE DEVICES 0 0 1.00 MEDICAL SUPPLIES CHARGED TO 71. 00 9, 721, 825 1.00 PATI ENTS _ 9, 721, 825 BONUS RECLASS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 8,063 1.00 2 00 ADMINISTRATIVE & GENERAL 5.00 185.085 0 0 2 00 0 3.00 OPERATION OF PLANT 7.00 34,078 0 3.00 4.00 DI ETARY 10.00 7, 414 0 0 4.00 0 5.00 CAFETERI A 11.00 6.054 0 5.00 NURSING ADMINISTRATION 0 6.00 13.00 56, 455 0 6.00 7.00 CENTRAL SERVICES & SUPPLY 14.00 6, 163 0 0 7.00 8.00 MEDICAL RECORDS & LIBRARY 16.00 16, 432 0 0 8.00 9 00 ADULTS & PEDIATRICS 30 00 142 961 O 9 00 10.00 INTENSIVE CARE UNIT 31.00 35, 507 0 10.00 11.00 NURSERY 43.00 13, 043 0 11.00 0 12.00 OPERATING ROOM 50.00 130, 494 0 12.00 0 DELIVERY ROOM & LABOR ROOM 52 00 3 988 13 00 0 13 00 14.00 RADI OLOGY-DI AGNOSTI C 54.00 45,834 0 0 14.00 3, 974 57.00 0 15.00 CT SCAN 15.00 16, 00 MAGNETIC RESONANCE IMAGING 58.00 3, 226 0 0 16,00 (MRI) I ABORATORY 0 17.00 60.00 46.587 0 17 00 18.00 RESPIRATORY THERAPY 65.00 20,076 0 18.00 19.00 PHYSICAL THERAPY 66.00 28, 708 0 0 19.00 OCCUPATIONAL THERAPY 0 67.00 5,028 20.00 0 20.00 21.00 SPEECH PATHOLOGY 68.00 1, 989 0 21.00 22.00 ELECTROCARDI OLOGY 69.00 4, 377 0 22.00 CARDI AC REHAB 76.00 0 23.00 23.00 4.211 0 RURAL HEALTH CLINIC 88.00 105, 168 0 24 00 24.00 25.00 RURAL HEALTH CLINIC II 88.01 211, 582 0 25.00 RURAL HEALTH CLINIC III 88. 02 26.00 22, 801 0 26.00 **LEMERGENCY** 27.00 91.00 67.744 27.00 28.00 HOME HEALTH AGENCY 101.00 27, 260 0 28.00 29.00 HOSPI CE 116.00 11, 563 0 0 29.00 30.00 PHYSICIANS' PRIVATE OFFICES 192.00 35, 740 0 0 30.00 31 00 THE WATERS 194 09 6,081 0 0 31 00 32.00 HENRY COUNTY RADIOLOGY 194.14 3,841 0 0 32.00 1, 301, 527 0 - MEDICAL DIRECTOR RECLASS 1.00 PHYSICIANS' PRIVATE OFFICES 192.00 25,000 0 1.00 25,000 - MED SUPPLIES RECLASS 1 00 OPERATING ROOM 50.00 10, 588, 764 0 1 00 10, 588, 764 - FOREST RIDGE STAFF RECLASS RURAL HEALTH CLINIC 88. 00 1.00 137, 608 0 1.00 137, 608 O BENEFIT RECLASS PHARMACY 212, 059 1.00 15.00 0 1.00 2.00 ADULTS & PEDIATRICS 30.00 0 20, 093 0 2.00 0 OPERATING ROOM 0 3 00 50.00 405, 454 3.00 4.00 RURAL HEALTH CLINIC 88.00 0 1, 036, 562 0 4.00 5.00 RURAL HEALTH CLINIC II 88.01 1, 773, 771 0 5.00

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

Provi der CCN: 15-0030

						5/26/2023 3:1	J3 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
6.00	RURAL HEALTH CLINIC III	88. 02	0	156, 204	0		6. 00
7.00	HOME HEALTH AGENCY	101. 00	0	13, 765	0		7. 00
8.00	HOSPI CE	116. 00	0	5, 796	0		8. 00
9.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	75, 385	0		9. 00
10.00	HENRY COUNTY RADIOLOGY	194. 14	0	1, 952	0		10.00
	0		0	3, 701, 041			
500.00	Grand Total: Decreases		2, 811, 512	24, 999, 572			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0030

						5/26/2023 3:0	3 pm
				Acquisitions			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	46, 000		-	0	0	1.00
2.00	Land Improvements	1, 514, 802			18, 295		2.00
3.00	Buildings and Fixtures	39, 705, 260	1, 900, 738	0	1, 900, 738	0	3.00
4.00	Building Improvements	1, 898, 222	405, 861	0	405, 861	0	4.00
5.00	Fixed Equipment	21, 978, 177	502, 703	0	502, 703	0	5.00
6.00	Movable Equipment	40, 255, 413	0	0	0	1, 100, 085	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	105, 397, 874	2, 827, 597	0	2, 827, 597	1, 100, 085	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	105, 397, 874	2, 827, 597	0	2, 827, 597	1, 100, 085	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	46, 000	0				1.00
2.00	Land Improvements	1, 533, 097	0				2.00
3.00	Buildings and Fixtures	41, 605, 998	0				3.00
4.00	Building Improvements	2, 304, 083	0				4.00
5.00	Fi xed Equi pment	22, 480, 880	0				5.00
6.00	Movable Equipment	39, 155, 328	0				6.00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	107, 125, 386	0				8.00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	107, 125, 386	0				10.00

Health Financial Systems HE	ENRY COUNTY MEN	IORIAL HOSPITAL	_	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Peri od:	Worksheet A-7	
				From 01/01/2022 Fo 12/31/2022		pared:
					5/26/2023 3:0	
	SUMMARY OF CAPITAL					
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see	instructions)	
				instructions)		
	9. 00	10. 00	11. 00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1	and 2			
1.00 NEW CAP REL COSTS-BLDG & FLXT	5, 367, 613	(232, 903	3 0	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	() (0	0	2.00
3.00 Total (sum of lines 1-2)	5, 367, 613	(232, 903	3 0	0	3.00
	SUMMARY C	F CAPITAL				
Cost Center Description	Other	Total (1)				
	Capi tal -Rel at	(sum of cols.				
	ed Costs (see	9 through 14)				
	instructions)					
	14. 00	15. 00				

	PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUMN 2, LINES 1 and 2	
1.00	NEW CAP REL COSTS-BLDG & FIXT	0 5, 600, 516	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0 0	2.00
3.00	Total (sum of lines 1-2)	0 5, 600, 516	3.00
	, ,		

Heal th	n Financial Systems HE	NRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS				Period: From 01/01/2022 Fo 12/31/2022	Date/Time Pre	pared:
		COMF	PUTATION OF RAT	TI 0S	ALLOCATION OF	5/26/2023 3: 0 OTHER CAPITAL	3 piii
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio (col. 1 - col. 2)	instructions)		
		1. 00	2.00	3.00	4.00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	67, 970, 058	0	67, 970, 058	0. 634491	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	39, 155, 328	0	39, 155, 328	0. 365509	0	2.00
3.00	Total (sum of lines 1-2)	107, 125, 386	0	107, 125, 386	1. 000000	0	3.00
		ALLOCATION OF OTHER CAPITAL			SUMMARY O		
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at	cols. 5			
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1. 00	NEW CAP REL COSTS-BLDG & FIXT	0	0	(5, 278, 719		1.00
2. 00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	(411, 326		2.00
3. 00	Total (sum of lines 1-2)	0	0	(5, 690, 045	0	3.00
			Sl.	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	
					instructions)		

11. 00

55, 899 0

55, 899

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

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

12. 00

0 0 0 13.00

0 0 0 14. 00

0 0 0 15.00

5, 334, 618 1. 00 411, 326 2. 00 5, 745, 944 3. 00

Provider CCN: 15-0030 Worksheet A-8 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/26/2023 3:03 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Cost Center Description Amount Line # Wkst. A-7 (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - NEW CAP Α -177, 004 NEW CAP REL COSTS-BLDG & 1.00 1.00 REL COSTS-BLDG & FLXT (chapter FLXT 2.00 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter EQUI P 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 -14, 993 ADMINISTRATIVE & GENERAL Trade, quantity, and time В 5.00 4.00 discounts (chapter 8) Refunds and rebates of 5.00 0 0.00 5.00 expenses (chapter 8) 6 00 Rental of provider space by 0 00 6 00 suppliers (chapter 8) 7.00 Tel ephone services (pay -24, 129 ADMINISTRATIVE & GENERAL 5.00 7.00 Α stations excluded) (chapter 21) 8.00 Television and radio service 0 8.00 0.00 (chapter 21) Parking lot (chapter 21) 9.00 0.00 9.00 10.00 Provi der-based physici an A-8-2 -7, 439, 426 10.00 adjustment Sale of scrap, waste, etc. 11.00 0.00 11.00 0 (chapter 23) 12.00 Related organization A-8-1 -2, 825, 701 12.00 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 -265, 404 CAFETERI A 14 00 Cafeteria-employees and guests В 11 00 O 14 00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 0 0.00 16.00 supplies to other than pati ents Sale of drugs to other than 17.00 0.00 17.00 pati ents 18.00 Sale of medical records and -13, 123 MEDI CAL RECORDS & LI BRARY 18.00 В 16.00 abstracts 19.00 Nursing and allied health 19.00 0.00 0 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 24.00 66.00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review -OUTILIZATION REVIEW-SNE 114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 1.00 26.00 COSTS-BLDG & FLXT
Depreciation - NEW CAP REL IFI XT ONEW CAP REL COSTS-MVBLE 27.00 27.00 2.00 COSTS-MVBLE EQUIP FOUL P 28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 Physicians' assistant 29.00 29.00 0.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 30.00 30.00 67.00 therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions)

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/26/2023 3:03 pm

					5/26/2023 3:0	3 pm
			Expense Classification on			
			To/From Which the Amount is	to be Adjusted		
				-		
Cost Center Descrip	tion Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
0001 0011101 B00011 p	(2)	7 1110 0111	0001 0011101	20 "	Ref.	
	1.00	2. 00	3.00	4. 00	5. 00	
31.00 Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00	0.00	31. 00
pathology costs in excess			SI ELGII I ATTIOLOGI	00.00		31.00
limitation (chapter 14)	3 01					
32.00 CAH HIT Adjustment for		0		0. 00	0	32.00
Depreciation and Interest	+			0.00	U	32.00
33. 00 OTHER OP REV - HUMAN RESO		E 7	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
- MIS	JUNGLO B	-57	LWFLOTEL BENEFIT IS DEPARTMENT	4.00	U	33.00
33. 01 OTHER OP REV	В	256 244	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
· · · · · · · · · · · · · · · · · · ·	В	1	DI ETARY		0	33. 02
	•			10.00	0	
33. 03 OTHER OP REV - PHARMACY	В		PHARMACY	15. 00	0	33. 03
33. 04 OTHER OP REV - LABORATORY	Y-LAB B	-308	LABORATORY	60. 00	0	33. 04
DRUG S		400 740	DUNGLOAL TUEDADY			
33. 05 OTHER OP REV - AQUATICS -	- HLTH B	-130, 718	PHYSI CAL THERAPY	66. 00	0	33. 05
PROG			5.15.1. 1.5.1. 5.1. 6.1.1.			
33.06 NC FAMILY INTERNAL	В	-22	RURAL HEALTH CLINIC	88. 00	0	33. 06
MEDICINE-OTHER OP					_	
33. 07 OTHER OP REV - NORTHFIELD			RURAL HEALTH CLINIC II	88. 01	0	33. 07
33.08 PUBLIC RELATIONS	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33.09 PUBLIC RELATIONS	A		NURSING ADMINISTRATION	13. 00	0	33. 09
33. 10 PUBLIC RELATIONS	A		RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 10
33. 11 PUBLIC RELATIONS	A		RURAL HEALTH CLINIC	88. 00	0	33. 11
33. 12 PUBLIC RELATIONS	A	-21, 747	RURAL HEALTH CLINIC II	88. 01	0	33. 12
33. 13 PUBLIC RELATIONS	A	-38, 776	RURAL HEALTH CLINIC III	88. 02	0	33. 13
33.14 AHA & IHA DUES	A	-9, 324	ADMINISTRATIVE & GENERAL	5. 00	0	33.14
33. 15 BENEFIT EXPENSE	A	3, 084, 472	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 15
33.16 NC FAMILY INTERNAL	I в	-56, 550	RURAL HEALTH CLINIC	88. 00	0	33. 16
MEDICINE-OTHER OP						
33. 17 MEDICAL DIRECTOR	A	95, 000	NURSING ADMINISTRATION	13. 00	0	33. 17
33. 18 HAF EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19 PHYSI CI AN RECRUI TMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 19
33. 20 PHYSI CI AN RECRUI TMENT	A		OPERATING ROOM	50.00	n	33. 20
50.00 TOTAL (sum of lines 1 thr		-13, 865, 920		33.00	J	50. 00
(Transfer to Worksheet A,		13, 003, 720				30.00
column 6, line 200.)						
(1) Description - all chapter re		1	040 D L 45 4			

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0030

Worksheet A-8-1

From 01/01/2022 12/31/2022 Date/Time Prepared: 5/26/2023 3:03 pm Li ne No. Cost Center Expense Items Amount of Amount Allowable Cost Included in Wks. A, column 3. 00 5. 00 1.00 2.00 4 00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 5. 00 ADMINISTRATIVE & GENERAL 1.00 RENT EXPENSE 15, 453 1.00 15. 00 PHARMACY RENT EXPENSE 8, 201 2.00 2.00 16.00 MEDICAL RECORDS & LIBRARY 3.00 RENT EXPENSE 9,368 31, 264 3.00 3.01 57. 00 CT SCAN RENT EXPENSE 982, 515 256, 030 3.01 58. OOMAGNETIC RESONANCE IMAGING (RENT EXPENSE 450,000 3.02 138, 824 3.02 60. 00 LABORATORY RENT EXPENSE 4.00 6, 253 35, 728 4.00 4.01 65. 00 RESPIRATORY THERAPY RENT EXPENSE 24, 434 -568 4.01 4.02 66. 00 PHYSI CAL THERAPY RENT EXPENSE 181, 810 773, 836 4.02 88. OO RURAL HEALTH CLINIC 243, 971 4.03 RENT EXPENSE 538, 201 4 03 88.01 RURAL HEALTH CLINIC II 4.04 RENT EXPENSE 624, 592 1, 299, 937 4.04 4.05 88. 02 RURAL HEALTH CLINIC III RENT EXPENSE 74, 042 152, 811 4.05 4.06 101.00 HOME HEALTH AGENCY RENT EXPENSE 10, 568 22, 659 4.06 116. 00 HOSPI CE RENT EXPENSE 22, 659 4.07 4.07 10, 564 4.08 192. 00 PHYSICIANS' PRIVATE OFFICES RENT EXPENSE 2, 255 92, 118 4.08 5.00 TOTALS (sum of lines 1-4) 1, 590, 912 4, 416, 613 5.00 Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
3 ()		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

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

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

3.01

3.02

4.00

4.01

4.02

4 03

4.04

4.05

4.06

4.07

0 4.07 -12,0954.08 -89, 863 4.08 5.00 -2, 825, 701 5.00 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELA	ATED ORGANIZATION(S) AND/OR HOME OFFICE:	
	·	

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

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

6. 00	MI SC	6.00
7.00		7.00
8.00		8. 00 9. 00
9.00		9.00
10.00		10. 00 100. 00
7. 00 8. 00 9. 00 10. 00		100.00

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

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

3.01

3.02

4.00

4.01

4.02

4.03

4.04

4.05

4.06

-726, 485

-311, 176

-29, 475

25,002

-592, 026

-294, 230

-675, 345

-78, 769

-12,091

0

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0

0

0

0

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0030

						To 12/31/2022	2 Date/Time Pro 5/26/2023 3:0	
	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	13. 00	NURSING ADMINISTRATION	25, 000	C	25, 000	211, 500	260	1.00
2.00	30.00	ADULTS & PEDIATRICS	2, 576, 042	2, 576, 042	2 0	211, 500	0	2.00
3.00	50.00	OPERATING ROOM	3, 344, 207	3, 312, 648	31, 559	246, 400	180	3.00
4.00	60.00	LABORATORY	56, 019		56, 019	211, 500	589	4.00
5.00	88. 01	RURAL HEALTH CLINIC II	1, 502, 442	1, 502, 442	2 0	211, 500	0	5.00
6.00	91. 00	EMERGENCY	95, 000	(95, 000	211, 500	560	6.00
7.00	0.00		0	(0	0	0	7. 00
8. 00	0.00		0	(0	0	0	8. 00
9. 00	0.00		0	(0	0	0	9. 00
10.00	0.00		0	(0	0	0	10.00
200.00			7, 598, 710		207, 578		1, 589	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Li mi t	Unadjusted RCE	Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		NURSING ADMINISTRATION	26, 438	1, 322		0	_	
2. 00		ADULTS & PEDIATRICS	0	C	-	0		
3.00		OPERATING ROOM	21, 323	1, 066		0	0	3.00
4. 00		LABORATORY	59, 891	2, 995		0	0	
5. 00		RURAL HEALTH CLINIC II	0	C	-	0	0	
6. 00		EMERGENCY	56, 942	2, 847		0	0	
7. 00	0.00		0	C	,	0	0	
8. 00	0.00		0	C	0	0	0	
9. 00	0.00		0		0	0	0	9. 00
10.00	0.00		0	(0	0	0	
200.00		0 1 0 1 (0)	164, 594			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	15. 00	16. 00	17. 00	18. 00	_	
1. 00		NURSING ADMINISTRATION	15.00	26, 438		18.00		1, 00
2. 00		ADULTS & PEDIATRICS		20, 430		2, 576, 042	1	2.00
3.00		OPERATING ROOM		21, 323	-			3.00
4. 00		LABORATORY		59, 891		3, 322, 004	1	4.00
5. 00		RURAL HEALTH CLINIC II		37, 071		1, 502, 442	1	5.00
6. 00		EMERGENCY		56, 942	1	38, 058		6.00
7. 00	0.00	EWENGENCT		30, 742	· ·	0 30,030		7.00
8. 00	0.00				-			8.00
9. 00	0.00)			9.00
10. 00	0.00				7			10.00
200.00				١ ٠	۷	7, 439, 426		200.00
200.00	ı l		1	104, 374	1 40, 274	1,437,420	T	1 200.00

| 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: 15-0030

				-	To 12/31/2022		
			CAPI TAL REL	ATED COSTS		5/26/2023 3:0	3 piii
	Coot Conton Decement on	Not Evnences	NEW DLDC 0	NEW MVDLE	EMDL OVEE	Culatatal	
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7) 0	1. 00	2. 00	4. 00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	5, 334, 618	5, 334, 618				1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	411, 326 20, 209, 931	35, 126	411, 32 2, 56			2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	16, 646, 586	765, 112	55, 89		20, 364, 875	5.00
7. 00	00700 OPERATION OF PLANT	3, 648, 605	1, 385, 309			5, 668, 566	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	458, 396	69, 221	5, 05		532, 674	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 022, 443 549, 306	40, 205 146, 050	2, 93 10, 67		1, 065, 585 822, 088	9. 00 10. 00
11. 00	01100 CAFETERI A	200, 480	39, 902	2, 91		338, 076	11.00
13.00	01300 NURSING ADMINISTRATION	3, 006, 277	87, 674	6, 40	5 883, 735	3, 984, 091	13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY	558, 584	144, 734	10, 57		810, 360	14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	4, 307, 939 901, 492	31, 606 21, 124	2, 30 ⁰ 1, 54		4, 341, 854 1, 181, 383	15. 00 16. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	701, 172	21,121	1,01	207, 221	1, 101, 000	10.00
30. 00	03000 ADULTS & PEDIATRICS	6, 795, 452	585, 109			9, 661, 183	30.00
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY	3, 417, 840	234, 736			4, 225, 552	31. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS	668, 057	62, 078	4, 53	5 204, 167	938, 837	43.00
50.00	05000 OPERATI NG ROOM	4, 292, 848	432, 423	31, 59	1 2, 042, 725	6, 799, 587	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	204, 272	31, 545	2, 30		300, 550	52.00
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	2, 810, 337 581, 716	229, 090 19, 890	16, 73 1, 45		3, 773, 636 665, 265	54. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	320, 576	19, 890	79		382, 700	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0			0	59.00
60.00	06000 LABORATORY	5, 840, 898	167, 154	12, 21		6, 749, 533	1
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPIRATORY THERAPY	0 1, 865, 317	0 49, 978		0 1 314, 265	0 2, 233, 211	60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 584, 242	21, 873			2, 253, 211	
67. 00	06700 OCCUPATI ONAL THERAPY	246, 073	3, 359	24	78, 701	328, 378	67.00
68. 00	06800 SPEECH PATHOLOGY	96, 899	3, 905	28		132, 229	68.00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	377, 116 384, 675	0		68, 520	445, 636 384, 675	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9, 721, 825	0			9, 721, 825	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	O	0		0 0	0	73. 00
76. 00	03950 CARDI AC REHAB	213, 616	14, 386	1, 05	1 65, 932	294, 985	76. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	5, 699, 069	0		1, 646, 285	7, 345, 354	88. 00
	08801 RURAL HEALTH CLINIC II	10, 139, 334	0		3, 312, 030	13, 451, 364	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	1, 361, 293	0		356, 915	1, 718, 208	88. 02
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 048, 339	202, 806	14, 81	1, 060, 445	6, 326, 406 0	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	1, 471, 026	0		426, 727	1, 897, 753	101.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						112 00
	11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
	11600 HOSPI CE	908, 883	0		180, 999	1, 089, 882	
118. 00		121, 305, 686	4, 835, 220	353, 23	7 19, 532, 833	120, 033, 409	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	2, 995	21	اه اه	2 21/	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	2, 067, 582	2, 993		559, 472	2, 627, 054	1
	07950 HOSPI TALI ST	0	0		0		194. 00
	07951 RENTAL	88, 894	0	21, 60	5 0	110, 499	
	07955 OTHER NONREIMBURSABLE COSTS 07956 DR AFZAL	219, 597 7, 567	0			219, 597	194. 05 194. 06
	07957 PHILLIPS HALL	0	0				194.00
194. 08	07958 OB DRS	O	0		0	0	194. 08
	07959 THE WATERS	467, 720	496, 403	36, 26	95, 185	1, 095, 573	
	07960 CAMBRI DGE CLTY 07961 WELL BEING	393	0				194. 10 194. 11
194. 12	07961 WELL BEING 07962 ACTIVATE HEALTH EMPLOYER CLINIC	64, 711	0			64, 711	
194. 13	07963 NEW CASTLE PEDIATRICS	O	0		0 0	0	194. 13
	07964 HENRY COUNTY ANISTHESI OLOGY	1, 949, 348	0	!	60, 133	2, 009, 481	
	07965 HENRY COUNTY ANESTHESIOLOGY 07966 NEW CASTLE IMMEDICATE CARE & FAMILY		0				194. 15 194. 16
200. 00			J				200.00
201.00	Negative Cost Centers		0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	126, 171, 498	5, 334, 618	411, 32	6 20, 247, 623	126, 171, 498	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0030

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/26/2023 3:03 pm Cost Center Description ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY E & GENERAL PLANT LINEN SERVICE 9. 00 5.00 7.00 10.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 20, 364, 875 5.00 7.00 00700 OPERATION OF PLANT 1, 091, 046 6, 759, 612 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 102, 525 103, 609 738, 808 8.00 205, 096 00900 HOUSEKEEPI NG 31, 350 9 00 9 00 60, 178 1, 362, 209 10.00 01000 DI ETARY 158, 230 218, 605 8, 420 45, 148 1, 252, 491 10.00 65, 071 01100 CAFETERI A 59, 724 12, 335 11.00 0 0 11.00 13.00 01300 NURSING ADMINISTRATION 766, 830 131, 230 0 27, 102 0 13.00 01400 CENTRAL SERVICES & SUPPLY 0 155.972 44.741 14 00 216, 636 0 14.00 15.00 01500 PHARMACY 835, 690 47, 307 0 9,770 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 227, 384 31,619 6,530 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 149, 296 30.00 1, 859, 517 180, 872 03000 ADULTS & PEDIATRICS 875, 783 986, 683 31.00 03100 INTENSIVE CARE UNIT 813, 305 351, 349 33, 622 72, 563 265, 808 31.00 180, 701 92, 918 19, 190 43.00 04300 NURSERY 11, 209 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 1, 308, 737 132, 833 50.00 05000 OPERATING ROOM 647, 244 133, 673 0 05200 DELIVERY ROOM & LABOR ROOM 57,848 47, 216 3, 404 9, 751 52.00 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 726, 323 342, 899 53, 762 70, 818 0 54.00 05700 CT SCAN 29, 771 6, 149 57.00 128,046 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 73, 659 16, 203 0 3, 346 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 59.00 06000 LABORATORY 934 51, 671 60.00 1, 299, 103 250, 193 0 60.00 06001 BLOOD LABORATORY 60.01 \cap 0 60.01 06500 RESPIRATORY THERAPY 429, 833 98, 733 20, 391 65.00 65.00 0 0 06600 PHYSI CAL THERAPY 66.00 395, 938 793, 071 13, 744 163, 790 0 66.00 06700 OCCUPATI ONAL THERAPY 63, 204 1, 038 67.00 5,027 2,526 0 67.00 06800 SPEECH PATHOLOGY 68.00 25, 451 5, 845 0 1, 207 0 68.00 69.00 06900 ELECTROCARDI OLOGY 85, 773 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 74,040 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 72.00 1, 871, 189 C 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 73.00 03950 CARDI AC REHAB 0 76.00 56, 777 21,533 0 4, 447 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 1, 413, 782 477, 490 4.593 98.614 0 2, 588, 979 88.01 08801 RURAL HEALTH CLINIC II 1, 234, 251 2, 214 254, 904 0 88.01 08802 RURAL HEALTH CLINIC III 31, 900 88.02 330, 709 154, 459 0 88.02 91 00 09100 EMERGENCY 1, 217, 662 303, 557 132 347 62, 692 O 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 365, 266 69, 355 0 14, 324 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 209, 773 69, 325 14, 317 0 116.00 0 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 6, 755, 130 1, 252, 491 118. 00 19, 183, 459 580, 254 1, 361, 283 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 4, 482 926 0 190.00 619 C 192.00 19200 PHYSICIANS' PRIVATE OFFICES 505, 637 0 0 192.00 0 C 194. 00 07950 HOSPI TALI ST C 0 0 0 194, 00 194. 01 07951 RENTAL 21, 268 0 0 194. 01 194. 05 07955 OTHER NONREI MBURSABLE COSTS 42, 266 0 194.05 0 13, 797 0 0 194.06 07956 DR AFZAL 0 194 06 1, 456 C 0 194. 07 07957 PHILLIPS HALL 6,000 0 194. 07 194.08 07958 OB DRS 9, 914 0 194.08 0 0 194. 09 07959 THE WATERS 0 194.09 0 128, 843 210,868 194. 10 07960 CAMBRIDGE CITY 0 0 0 194, 10 194. 11 07961 WELL BEING 0 0 0 0 0 194. 11 76 194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC 12, 455 0 0 0 194. 12 194. 13 07963 NEW CASTLE PEDIATRICS 0 194. 13 0 0 0 194. 14 07964 HENRY COUNTY RADI OLOGY 0 386, 771 C 0 194, 14 194. 15 07965 HENRY COUNTY ANESTHESI OLOGY 0 0 0 194. 15 194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY 0 C 0 0 0 194. 16 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers \cap 0 201.00 TOTAL (sum lines 118 through 201) 738, 808 1, 252, 491 202. 00 202.00 20, 364, 875 6.759.612 1, 362, 209

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0030

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: 5/26/2023 3:03 pm

					5/26/2023 3:0	3 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMINISTRATIO N	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS		10.00		10.00	10100	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	475, 206					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	36, 457	4, 945, 710				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	10, 230		1, 237, 939			14.00
15. 00 01500 PHARMACY	0	0	2, 111	5, 236, 732		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	20, 999	0	229	0	1, 468, 144	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	92, 885	932, 560	30, 706	0	97, 656	
31. 00 03100 INTENSIVE CARE UNIT	24, 189		11, 385	0	52, 838	31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	8, 227	82, 594	2, 396	0	35, 854	43.00
50. 00 O5000 OPERATING ROOM	76, 680	769, 861	77, 630	ol	278, 346	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 515		733	o	270, 010	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	37, 248		12, 427	Ö	225, 977	54.00
57.00 05700 CT SCAN	2, 751	0	10, 584	О	66, 519	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 735	0	1, 631	0	15, 568	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY	47, 299	0	193, 661	0	238, 243	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65. 00 06500 RESPIRATORY THERAPY	14, 775	0	3, 398	O O	14, 625	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	36, 452 3, 822	0	3, 154 111	0	9, 907 1, 415	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 284	0	13	0	472	68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 438	Ö	5, 360	o	12, 738	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	31, 028	Ö	33, 967	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	793, 107	О	70, 294	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	5, 236, 732	0	73.00
76. 00 03950 CARDI AC REHAB	4, 024	40, 400	442	0	1, 415	76. 00
OUTPATIENT SERVICE COST CENTERS		0.40.050				
88. 00 08800 RURAL HEALTH CLINIC	0	840, 952	4, 211	0	8, 020	88.00
88. 01 08801 RURAL HEALTH CLINIC II 88. 02 08802 RURAL HEALTH CLINIC III	0	1, 353, 390 163, 916	9, 476 2, 253	0	40, 100 0	88. 01 88. 02
91. 00 09100 EMERGENCY	49, 196	493, 925	38, 421	0	258, 529	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	47, 170	473, 723	30, 421	o o	230, 327	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	2, 431	0	3, 774	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					4 007	114.00
116. 00 11600 HOSPI CE	475 204	0	1, 041	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	475, 206	4, 945, 710	1, 237, 939	5, 236, 732	1, 468, 144	118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	ő	0	o		192.00
194. 00 07950 H0SPI TALI ST	0	0	0	Ö		194.00
194. 01 07951 RENTAL	0	0	0	o	0	194. 01
194. 05 07955 OTHER NONREI MBURSABLE COSTS	0	0	0	0	0	194. 05
194. 06 07956 DR AFZAL	0	0	0	0		194. 06
194. 07 07957 PHI LLI PS HALL	0	0	0	0		194. 07
194. 08 07958 OB DRS	0	0	0	0		194. 08
194. 09 07959 THE WATERS	0	0	0	0		194.09
194. 10 07960 CAMBRI DGE CITY 194. 11 07961 WELL BEING	0	٥	0	o o		194. 10 194. 11
194.11 07961 WELL BEING 194.12 07962 ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	٥		194. 11
194. 13 07963 NEW CASTLE PEDIATRICS	0	n	0	0		194. 12
194. 14 07964 HENRY COUNTY RADIOLOGY	Ö	ő	Ö	o		194. 14
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY	0	o	0	o		194. 15
194.16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	o	0	o		194. 16
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)	475, 206	4, 945, 710	1, 237, 939	5, 236, 732	1, 468, 144	202.00

| 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: 15-0030

			-	To 12/31/2022 Date/Time Pr 5/26/2023 3:	
Cost Center Description	Subtotal	Intern &	Total	3/20/2023 3.	US PIII
		Resi dents			
		Cost & Post			
		Stepdown Adjustments			
	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS					
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
5. 00 00500 ADMINI STRATI VE & 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 11. 00 01100 CAFETERI A					10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 01500 PHARMACY					15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY					16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	14, 867, 141	o	14, 867, 14	1	30.00
31. 00 03100 I NTENSI VE CARE UNI T	6, 093, 470		6, 093, 470		31.00
43. 00 04300 NURSERY	1, 371, 926	0	1, 371, 92		43.00
ANCILLARY SERVICE COST CENTERS				-	
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	10, 224, 591	0	10, 224, 59 ⁻ 447, 270		50. 00 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	447, 270 5, 243, 090	0	5, 243, 09		54.00
57. 00 05700 CT SCAN	909, 085	o	909, 08!		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	495, 842	О	495, 842		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0			59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	8, 830, 637 0	0 0	8, 830, 63	7	60. 00 60. 01
65. 00 06500 RESPI RATORY THERAPY	2, 814, 966	0	2, 814, 96	5	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 473, 164	O	3, 473, 16		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	405, 521	0	405, 52		67.00
68. 00 06800 SPEECH PATHOLOGY	166, 501	0	166, 50		68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	552, 945 523, 710	0	552, 94! 523, 710		69. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	12, 456, 415	Ö	12, 456, 41!		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 236, 732	О	5, 236, 73		73.00
76. 00 03950 CARDI AC REHAB	424, 023	0	424, 02	3	76. 00
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	10, 193, 016	0	10, 193, 010	6	88.00
88. 01 08801 RURAL HEALTH CLINIC II	18, 934, 678	o	18, 934, 678		88. 01
88.02 08802 RURAL HEALTH CLINIC III	2, 401, 445	0	2, 401, 44		88. 02
91. 00 09100 EMERGENCY	8, 882, 735	0	8, 882, 73	5	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	2, 352, 903	O	2, 352, 90	3	101.00
SPECIAL PURPOSE COST CENTERS	2, 332, 703	<u> </u>	2, 332, 70.	5	101.00
113. 00 11300 I NTEREST EXPENSE					113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	4 00/ 005		4 007 00	_	114.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 386, 225 118, 688, 031	0 0	1, 386, 22! 118, 688, 03		116. 00 118. 00
NONREI MBURSABLE COST CENTERS	110,000,031	<u> </u>	110,000,03	1	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9, 241	0	9, 24	1	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 132, 691	0	3, 132, 69		192.00
194. 00 07950 HOSPI TALI ST	121 747	0	131, 76	0	194.00
194. 01 07951 RENTAL 194. 05 07955 OTHER NONREIMBURSABLE COSTS	131, 767 275, 660	0	275, 660		194. 01 194. 05
194. 06 07956 DR AFZAL	9, 023	o	9, 02		194.06
194. 07 07957 PHI LLI PS HALL	6, 000	o	6, 000		194. 07
194. 08 07958 OB DRS	9, 914	0	9, 91		194.08
194. 09 07959 THE WATERS 194. 10 07960 CAMBRI DGE CLTY	1, 435, 284 0	0	1, 435, 28	4 O	194. 09 194. 10
194. 11 07961 WELL BEING	469	0	469	-	194. 10
194.12 07962 ACTIVATE HEALTH EMPLOYER CLINIC	77, 166		77, 16		194. 12
194. 13 07963 NEW CASTLE PEDIATRICS	0		(0	194. 13
194.14 07964 HENRY COUNTY RADIOLOGY	2, 396, 252	0	2, 396, 25	2	194. 14
194. 15 07965 HENRY COUNTY ANESTHESIOLOGY 194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	0))	194. 15 194. 16
200.00 Cross Foot Adjustments	0	o	Ò		200.00
201.00 Negative Cost Centers	0	O	(o	201.00
202.00 TOTAL (sum lines 118 through 201)	126, 171, 498	0	126, 171, 498	3	202.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0030

			Ť	0 12/31/2022	Date/Time Pre 5/26/2023 3:0	
		CAPI TAL REI	ATED COSTS		372072023 3.0	3 piii
Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
cost center bescription	Assigned New	FLXT	EQUI P	Subtotal	BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs 0	1. 00	2.00	2A	4. 00	
GENERAL SERVICE COST CENTERS	0 1	1.00	2.00	ZA	4.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	35, 126	2, 566	37, 692	37, 692	2. 00 4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	0	765, 112			5, 396	5.00
7. 00 00700 OPERATION OF PLANT	0	1, 385, 309			993	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	69, 221	5, 057			8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	40, 205 146, 050	2, 937 10, 670		0 216	9. 00 10. 00
11. 00 01100 CAFETERI A	O	39, 902			177	11.00
13.00 01300 NURSING ADMINISTRATION	0	87, 674			l	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	0	144, 734 31, 606			l e	14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	21, 124	1, 543		479	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	585, 109		·	4, 168	30.00
31. 00 03100 I NTENS I VE CARE UNI T 43. 00 04300 NURSERY	0	234, 736 62, 078			l '	31. 00 43. 00
ANCILLARY SERVICE COST CENTERS	-	5_, 5.5	.,	3373.3		
50. 00 05000 OPERATING ROOM	0	432, 423	31, 591	464, 014	3, 804	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 54.00 05400 RADIOLOGY-DIAGNOSTIC	0	31, 545 229, 090			116 1, 336	52. 00 54. 00
57. 00 05700 CT SCAN	O	19, 890	1, 453		116	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10, 825	791	11, 616	l e	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	0 167, 154	0 12, 211	0 179, 365	0 1, 358	59. 00 60. 00
60. 01 06001 BLOOD LABORATORY	0	107, 134	12, 211	177, 303	1, 330	60.01
65. 00 06500 RESPIRATORY THERAPY	0	49, 978		53, 629	585	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	21, 873			837	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	3, 359 3, 905	245 285		147 58	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	128	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	72. 00 73. 00
76. 00 03950 CARDI AC REHAB	0	14, 386	1, 051	15, 437	123	76.00
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C					2.0//	00.00
88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II	0	0	0		3, 066 6, 151	88. 00 88. 01
88. 02 08802 RURAL HEALTH CLINIC III	O	0	Ö	0	665	88. 02
91. 00 09100 EMERGENCY	0	202, 806	14, 816	217, 622	1, 975	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				[0]		92.00
101. 00 10100 HOME HEALTH AGENCY	0	0	C	0	795	101.00
SPECIAL PURPOSE COST CENTERS	1			T T		111 00
113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
116. 00 11600 HOSPI CE	0	0	O	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	4, 835, 220	353, 237	5, 188, 457	36, 361	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	2, 995	219	3, 214	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
194. 00 07950 H0SPI TALI ST 194. 01 07951 RENTAL	0	0	21, 605	0	l	194. 00 194. 01
194.05 07955 OTHER NONREIMBURSABLE COSTS	0	0	21,003	21, 605 0		194.01
194.06 07956 DR AFZAL	0	0	0	0	0	194. 06
194. 07 07957 PHI LLI PS HALL	0	0	0	0		194. 07 194. 08
194.08 07958 0B DRS 194.09 07959 THE WATERS	0	496, 403	36, 265	532, 668	l e	194.00
194. 10 07960 CAMBRI DGE CITY	0	0	0	0	0	194. 10
194. 11 07961 WELL BEING	0	0	0	0	l e	194. 11
194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC 194. 13 07963 NEW CASTLE PEDIATRICS		0		0	l e	194. 12 194. 13
194. 14 07964 HENRY COUNTY RADIOLOGY	0	0	ď	Ö	l e	194. 14
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY	0	0	0	0	l e	194. 15
194.16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY 200.00 Cross Foot Adjustments	0	0	C	0	l e	194. 16 200. 00
201.00 Negative Cost Centers]	0	0		0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	5, 334, 618	411, 326	5, 745, 944	37, 692	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0030

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/26/2023 3:03 pm

					5/26/2023 3:0	3 pm
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
OFNEDAL CERVILOR COCT OFNITERS	5. 00	7. 00	8. 00	9. 00	10. 00	
GENERAL SERVICE COST CENTERS						1 00
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT 2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL	924 402					4. 00 5. 00
7.00 OO700 OPERATION OF PLANT	826, 403 44, 277	1, 531, 783				7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	4, 161	23, 479				8.00
9. 00 00900 HOUSEKEEPI NG	8, 323	13, 637		69, 427		9.00
10. 00 01000 DI ETARY	6, 421	49, 538		2, 301	216, 358	10.00
11. 00 01100 CAFETERI A	2, 641	13, 534		629	210, 330	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	31, 120	29, 738		1, 381	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	6, 330	49, 092		2, 280	0	14.00
15. 00 01500 PHARMACY	33, 914	10, 720		498	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	9, 228	7, 165	0	333	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	1	,				
30. 00 03000 ADULTS & PEDI ATRI CS	75, 464	198, 459	20, 594	9, 218	170, 442	30.00
31.00 03100 INTENSIVE CARE UNIT	33, 006	79, 619	4, 638		45, 916	31.00
43. 00 04300 NURSERY	7, 333	21, 056	1, 546	978	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	53, 112	146, 671	18, 324	6, 813	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 348	10, 700	470	497	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	29, 476	77, 704	7, 416	3, 609	0	54.00
57.00 05700 CT SCAN	5, 196	6, 746	0	313	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 989	3, 672	0	171	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY	52, 721	56, 696	129	2, 634	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	_	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	17, 444	22, 374	0	1, 039	0	65.00
66. 00 06600 PHYSI CAL THERAPY	16, 068	179, 716			0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 565	1, 139		53	0	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 033	1, 325		62	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 481	0	_	0	0	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	3, 005	0		0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	75, 937	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03950 CARDI AC REHAB	0	4, 880	0	227	0	73. 00 76. 00
76. 00 03950 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS	2, 304	4, 880		221	U	76.00
88. 00 08800 RURAL HEALTH CLINIC	57, 375	108, 203	634	5, 026	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	105, 014	279, 687	305		0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	13, 421	35, 002		1, 626	0	88. 02
91. 00 09100 EMERGENCY	49, 416	68, 789		3, 195	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			1	-,	_	92.00
OTHER REIMBURSABLE COST CENTERS	'			,		
101.00 10100 HOME HEALTH AGENCY	14, 823	15, 716	0	730	0	101.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
116. 00 11600 HOSPI CE	8, 513	15, 710	0	730	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	778, 459	1, 530, 767	80, 045	69, 380	216, 358	118. 00
NONRE MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	25	1, 016	0	47		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	20, 520	0	0	0		192. 00
194. 00 07950 HOSPI TALI ST	0	0	0	0		194. 00
194. 01 07951 RENTAL	863	0	0	0		194. 01
194.05 07955 OTHER NONREIMBURSABLE COSTS	1, 715	0	1, 903	0		194. 05
194. 06 07956 DR AFZAL	59	0	0	0		194. 06
194. 07 07957 PHI LLI PS HALL	0	0				194. 07
194. 08 07958 OB DRS	0	0	1, 368			194. 08
194. 09 07959 THE WATERS	8, 558	0	17, 774	0		194. 09
194. 10 07960 CAMBRI DGE CI TY	0	0	0	0		194. 10
194. 11 07961 WELL BEING	3	0	0	0		194. 11
194. 12 07962 ACTI VATE HEALTH EMPLOYER CLINIC	505	0	0	0		194. 12
194. 13 07963 NEW CASTLE PEDI ATRI CS	15 (0)	0		0		194. 13
194. 14 07964 HENRY COUNTY RADI OLOGY	15, 696	0		0		194. 14
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY	0	0		0		194. 15
194.16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY 200.00 Cross Foot Adjustments	١	0		۷	Ü	194. 16 200. 00
201.00 Negative Cost Centers		^	0	0	0	200.00
202.00 TOTAL (sum lines 118 through 201)	826, 403	1, 531, 783	101, 918	69, 427	216, 358	
202.00 10 m. (30m 11103 110 through 201)	020, 403	1, 551, 765	101,710	07, 727	210, 330	1-02.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0030

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: | To | To | Period | Pe

			Ic	12/31/2022	Date/IIme Pre 5/26/2023 3:0	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	5 piii
		N	SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16.00	
GENERAL SERVICE COST CENTERS	,					
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00 00900 LAUNDRY & LITNEN SERVICE						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	59, 798					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	4, 588	162, 552				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	1, 287	0	214, 477			14.00
15. 00 01500 PHARMACY	0	О	366	79, 413		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	2, 642	0	40	0	42, 554	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	11, 688	30, 651	5, 320	0	2, 831	30.00
31.00 03100 INTENSIVE CARE UNIT	3, 044	7, 982	1, 972	0	1, 532	31.00
43. 00 04300 NURSERY	1, 035	2, 715	415	0	1, 039	43.00
ANCILLARY SERVICE COST CENTERS	0 (40	25 202	12 450	0	8. 069	E0 00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 649 317	25, 303 830	13, 450 127	0	8,069	50. 00 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 687	030	2, 153	0	6, 550	54.00
57. 00 05700 CT SCAN	346	0	1, 834	0	1, 928	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	344	0	283	0	451	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	ol	0	o	0	59. 00
60. 00 06000 LABORATORY	5, 952	o	33, 552	0	6, 905	60.00
60. 01 06001 BLOOD LABORATORY	0	o	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	1, 859	0	589	0	424	65.00
66. 00 06600 PHYSI CAL THERAPY	4, 587	0	546	0	287	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	481	0	19	0	41	67.00
68. 00 06800 SPEECH PATHOLOGY	162	0	2	0	14	68.00
69. 00 06900 ELECTROCARDI OLOGY	433	0	929	0	369	69.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENT	0	0	5, 376 137, 407	O O	985 2, 037	71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	137, 407	79, 413	2,037	72.00
76. 00 03950 CARDI AC REHAB	506	1, 328	77	77, 413	41	76. 00
OUTPATIENT SERVICE COST CENTERS	000	1, 020	,,,	<u> </u>		70.00
88. 00 08800 RURAL HEALTH CLINIC	0	27, 640	730	0	232	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	44, 482	1, 642	0	1, 162	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	5, 387	390	0	0	88. 02
91. 00 09100 EMERGENCY	6, 191	16, 234	6, 657	0	7, 493	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	O	o	421	o	100	101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	U U	421	<u> </u>	109	101.00
113. 00 11300 NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
116. 00 11600 HOSPI CE	0	0	180	0	55	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	59, 798	162, 552	214, 477	79, 413	42, 554	118. 00
NONREI MBURSABLE COST CENTERS			.1	.1		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
194. 00 07950 H0SPI TALI ST 194. 01 07951 RENTAL	0	0	0	0		194. 00 194. 01
194. 05 07955 OTHER NONREI MBURSABLE COSTS	0	0	0	0		194.01
194. 06 07956 DR AFZAL	0	0	0	0		194. 06
194. 07 07957 PHI LLI PS HALL	0	0	0	0		194. 00
194. 08 07958 OB DRS	Ö	Ö	0	o o		194. 08
194. 09 07959 THE WATERS	O	o	0	0		194. 09
194. 10 07960 CAMBRI DGE CITY	0	О	0	0	0	194. 10
194. 11 07961 WELL BEING	0	o	0	0	0	194. 11
194.12 07962 ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194. 12
194. 13 07963 NEW CASTLE PEDIATRICS	0	0	0	0		194. 13
194. 14 07964 HENRY COUNTY RADI OLOGY	이	0	0	0		194. 14
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY	0	0	0	0		194. 15
194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY	이	0	0	O	0	194. 16
200.00 Cross Foot Adjustments				۵	^	200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	59, 798	162, 552	214, 477	79, 413	42, 554	201.00
202.00 TOTAL (Suil TITIES TTO LITTOUGH 201)	37, 770	102, 332	214,477	77,413	42, 334	202.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0030

				Τ̈́	o 12/31/2022 Date/Time Pr 5/26/2023 3:	
	Cost Center Description	Subtotal	Intern &	Total	372072023 3.	J piii
			Resi dents			
			Cost & Post			
			Stepdown Adjustments			
		24. 00	25. 00	26. 00		
4 00	GENERAL SERVICE COST CENTERS			1	T	4
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP					1.00 2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
7.00	00700 OPERATION OF PLANT					7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE					8. 00 9. 00
10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY			•		10.00
	01100 CAFETERI A					11.00
	01300 NURSING ADMINISTRATION					13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14.00
	01600 MEDICAL RECORDS & LIBRARY			•		15. 00 16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDIATRICS	1, 156, 689	0			30.00
	03100 INTENSIVE CARE UNIT	434, 327	0			31.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	103, 110	0	103, 110	'i	43.00
50.00	05000 OPERATING ROOM	749, 209	0	749, 209		50.00
	05200 DELIVERY ROOM & LABOR ROOM	49, 255	0			52.00
	05400 RADI OLOGY-DI AGNOSTI C	378, 757	0	1		54.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	37, 822 19, 620	0			57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	17, 020	0			59.00
	06000 LABORATORY	339, 312	0	339, 312		60.00
60. 01	06001 BLOOD LABORATORY	0	0)	60. 01
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	97, 943 235, 756	0			65. 00 66. 00
	06700 OCCUPATIONAL THERAPY	8, 398		1		67.00
	06800 SPEECH PATHOLOGY	6, 846	0			68.00
	06900 ELECTROCARDI OLOGY	5, 340	0			69.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	9, 366	0			71.00
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	215, 381 79, 413	0	1		72. 00 73. 00
	03950 CARDI AC REHAB	24, 923	Ö			76.00
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC	202, 906 451, 434	0	1		88.00
	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	56, 491	0			88. 01 88. 02
91. 00	09100 EMERGENCY	395, 829	Ö			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00
101 00	OTHER REIMBURSABLE COST CENTERS	22 504	0	22 504	1	101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	32, 594	0	32, 594		101.00
	11300 I NTEREST EXPENSE					113.00
	11400 UTILIZATION REVIEW-SNF					114. 00
	11600 HOSPI CE	25, 525		1		116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	5, 116, 246	0	5, 116, 246	9	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 302	0			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	21, 562	0			192. 00
	07950 HOSPI TALI ST	0	0	-		194.00
	07951 RENTAL 07955 OTHER NONREIMBURSABLE COSTS	22, 468 3, 618	0	1		194. 01 194. 05
	07956 DR AFZAL	59	Ö	i .		194. 06
	07957 PHI LLI PS HALL	828	0	828	3	194. 07
	07958 OB DRS	1, 368	0	,		194. 08
	07959 THE WATERS 07960 CAMBRIDGE CITY	559, 177 0	0			194. 09 194. 10
	07961 WELL BEING	3	0	1		194. 10
194. 12	07962 ACTIVATE HEALTH EMPLOYER CLINIC	505	0	505	5	194. 12
194. 13	07963 NEW CASTLE PEDIATRICS	0	0			194. 13
	07964 HENRY COUNTY RADI OLOGY 07965 HENRY COUNTY ANESTHESI OLOGY	15, 808	0	15, 808		194. 14 194. 15
	07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0				194. 15
200.00		0	Ö			200.00
201.00		0	0	1		201.00
202. 00	TOTAL (sum lines 118 through 201)	5, 745, 944	0	5, 745, 944	·I	202. 00

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0030 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/26/2023 3:03 pm CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliatio ADMINISTRATIV **FOULP** BENEFITS E & GENERAL FI XT n (SQUARE (SQUARE DEPARTMENT (ACCUM. FEET) FEET) (GROSS COST) SALARI ES) 1. 00 2.00 4.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 263.645 1 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 278, 261 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 736 58, 460, 583 4.00 4.00 1.736 5.00 00500 ADMINISTRATIVE & GENERAL 37, 813 8, 365, 257 5.00 37,813 -20, 364, 875 105, 806, 623 7.00 00700 OPERATION OF PLANT 68, 464 68, 464 1,540,214 5, 668, 566 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 3, 421 3, 421 532, 674 8.00 1, 987 1, 065, 585 00900 HOUSEKEEPI NG 1, 987 0 9.00 9 00 0 0 10.00 01000 DI ETARY 7, 218 7, 218 335, 103 822, 088 10.00 11.00 01100 CAFETERI A 1, 972 1, 972 273, 652 0 338, 076 11.00 01300 NURSING ADMINISTRATION 0 13.00 4, 333 4, 333 2, 551, 588 3, 984, 091 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 7 153 7.153 278, 529 810, 360 14 00 15.00 01500 PHARMACY 1, 562 1,562 0 4, 341, 854 15.00 01600 MEDICAL RECORDS & LIBRARY 742, 678 16.00 1.044 1.044 1, 181, 383 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 28 917 28 917 6, 461, 372 0 9, 661, 183 30.00 31.00 03100 INTENSIVE CARE UNIT 11,601 11,601 1, 604, 827 0 4, 225, 552 31.00 43.00 04300 NURSERY 3,068 3,068 589, 486 938, 837 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 21, 371 21, 371 5, 897, 915 0 6, 799, 587 50.00 05200 DELIVERY ROOM & LABOR ROOM 1, 559 1, 559 180, 247 0 300, 550 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 322 11, 322 2,071,543 3, 773, 636 54.00 0 05700 CT SCAN 179, 607 665, 265 57 00 57 00 983 983 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 535 535 145, 830 382, 700 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 59.00 0 06000 LABORATORY 2, 105, 605 60.00 8, 261 8, 261 6, 749, 533 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 0 06500 RESPIRATORY THERAPY 2, 470 2, 470 907, 371 2, 233, 211 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 1,081 1,081 1, 297, 529 2,057,108 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 227, 233 328, 378 67.00 166 166 06800 SPEECH PATHOLOGY 68 00 193 193 89, 909 132, 229 68 00 0 06900 ELECTROCARDI OLOGY 197, 836 445, 636 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 384, 675 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 9, 721, 825 72.00 72.00C 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 r \cap O 73.00 294, 985 76.00 03950 CARDI AC REHAB 711 711 190, 364 76.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 88 00 0 4, 753, 281 0 7, 345, 354 88.01 08801 RURAL HEALTH CLINIC II 0 C 9, 562, 827 0 13, 451, 364 88.01 88.02 08802 RURAL HEALTH CLINIC III 1,030,512 0 1, 718, 208 88.02 3, 061, 798 09100 EMERGENCY 10,023 10,023 91.00 6, 326, 406 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 1, 232, 079 0 1, 897, 753 101. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 522, 594 1, 089, 882 116, 00 SUBTOTALS (SUM OF LINES 1 through 117) -20, 364, 875 118.00 238, 964 238, 964 56, 396, 786 99, 6<u>68, 534</u> 118. 00 NONREI MBURSABLE COST CENTERS 3, 214 190. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 148 148 2, 627, 054 192. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 1, 615, 350 0 C 194. 00 07950 HOSPI TALI ST 0 0 0 0 194.00 194. 01 07951 RENTAL 0 0 0 110, 499 194. 01 14.616 194. 05 07955 OTHER NONREI MBURSABLE COSTS 0 0 0 219, 597 194. 05 C o 7, 567 194. 06 194.06 07956 DR AFZAL 0 0 0 194. 07 07957 PHILLIPS HALL 0 0 0 0 194.07 194. 08 07958 OB DRS 0 0 194.08 0 194. 09 07959 THE WATERS 24.533 24.533 274, 826 1, 095, 573 194. 09 194. 10 07960 CAMBRIDGE CITY 0 194. 10 0 194. 11 07961 WELL BEING 0 0 0 393 194. 11

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64, 711 194. 12

2, 009, 481 194. 14

0 194. 13

0 194. 15

0 194. 16

200.00

201.00

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0

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173, 621

200.00 201.00

194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC

194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY

Cross Foot Adjustments

Negative Cost Centers

194. 13 07963 NEW CASTLE PEDIATRICS

194. 14 07964 HENRY COUNTY RADIOLOGY

194. 15 07965 HENRY COUNTY ANESTHESI OLOGY

Health Fina	ancial Systems HE	NRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2022 Fo 12/31/2022		
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG & FLXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		1. 00	2. 00	4. 00	5A	5. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	5, 334, 618	411, 326	20, 247, 62	3	20, 364, 875	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	20. 234095	1. 478202	0. 34634	7	0. 192473	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			37, 69	2	826, 403	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00064	5	0. 007811	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

COCT ALL	nanciai systems		Drovi don C			Wastabaat D 1	
CUST ALL	OCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2022 o 12/31/2022		pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	5/26/2023 3:0 CAFETERIA (FTE'S)	3 pm
		7. 00	8.00	9.00	10.00	11. 00	
1. 00 00 2. 00 00 4. 00 00 5. 00 00 7. 00 00 8. 00 00 9. 00 00 10. 00 01 11. 00 01	NERAL SERVICE COST CENTERS 1100 NEW CAP REL COSTS-BLDG & FIXT 1200 NEW CAP REL COSTS-MVBLE EQUIP 1400 EMPLOYEE BENEFITS DEPARTMENT 1500 ADMINISTRATIVE & GENERAL 15700 OPERATION OF PLANT 1800 LAUNDRY & LINEN SERVICE 1900 HOUSEKEEPING 100 CAFETERIA	223, 192 3, 421 1, 987 7, 218 1, 972	705, 361 7 29, 931 8 8, 039 2 0	217, 784 7, 218 1, 972	8, 868 0	686, 013	
	300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY	4, 333 7, 153		4, 333 7, 153		52, 630 14, 768	
	500 PHARMACY	1, 562	l .			0	1
	600 MEDI CAL RECORDS & LI BRARY	1, 044	l <u> </u>	1, 044	0	30, 314	16. 00
	PATIENT ROUTINE SERVICE COST CENTERS OOO ADULTS & PEDIATRICS	28, 917	142, 537	28, 917	6, 986	134, 090] 30. 00
	100 INTENSIVE CARE UNIT	11, 601				34, 920	
	300 NURSERY	3, 068	10, 702	3, 068	0	11, 876	43.00
	CILLARY SERVICE COST CENTERS OOO OPERATING ROOM	21, 371	126, 819	21, 371	0	110, 696	50. 00
52. 00 05 54. 00 05 57. 00 05 58. 00 05 59. 00 05	1200 DELIVERY ROOM & LABOR ROOM 1400 RADIOLOGY-DIAGNOSTIC 1700 CT SCAN 1800 MAGNETIC RESONANCE IMAGING (MRI) 1900 CARDIAC CATHETERIZATION	1, 559 11, 322 983 535 0	3, 250 2 51, 328 3 0 5 0	1, 559 11, 322 983 535 0	0 0 0 0	3, 631 53, 771 3, 971 3, 949 0	52. 00 54. 00 57. 00 58. 00 59. 00
	000 LABORATORY 001 BL00D LABORATORY	8, 261			0	68, 282 0	
	500 RESPIRATORY THERAPY	3, 260	-			21, 329	1
	600 PHYSI CAL THERAPY	26, 186				52, 622	
	0700 OCCUPATI ONAL THERAPY	166		1		5, 518	1
	800 SPEECH PATHOLOGY 900 ELECTROCARDI OLOGY	193	1	193 0		1, 854 4, 963	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		-	0		4, 703	1
72.00 07	200 IMPL. DEV. CHARGED TO PATIENT	C	o	0	0	0	
	300 DRUGS CHARGED TO PATIENTS	0		_ ~	0	0	73.00
	1950 CARDI AC REHAB TPATI ENT SERVI CE COST CENTERS	711	0	711	0	5, 809	76. 00
	8800 RURAL HEALTH CLINIC	15, 766	4, 385	15, 766	0	0	88. 00
	801 RURAL HEALTH CLINIC II	40, 753				0	88. 01
	1802 RURAL HEALTH CLINIC III	5, 100 10, 023		-,		0 71, 020	88. 02 91. 00
	2200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 023	120, 333	10,023	J	71,020	92.00
	HER REIMBURSABLE COST CENTERS						
	1100 HOME HEALTH AGENCY	2, 290) 0	2, 290	0	0	101. 00
	ECIAL PURPOSE COST CENTERS 300 INTEREST EXPENSE] 113. 00
1	400 UTI LI ZATI ON REVI EW-SNF						114. 00
	600 HOSPI CE	2, 289		2, 289	0		116.00
118. 00 NO	SUBTOTALS (SUM OF LINES 1 through 117 NREIMBURSABLE COST CENTERS) 223, 044	553, 986	217, 636	8, 868	686, 013]118.00
	0000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	148	3 0	148	0	0	190. 00
	200 PHYSICIANS' PRIVATE OFFICES	C	0		_		192. 00
	'950 H0SPI TALI ST '951 RENTAL	C	0	0	_		194. 00 194. 01
	1955 OTHER NONREI MBURSABLE COSTS		13, 172				194.01
	956 DR AFZAL	C	0	0	-		194. 06
	957 PHILLIPS HALL	C	-,	1			194.07
	958 OB DRS 959 THE WATERS		9, 465 123, 010	1			194. 08 194. 09
	960 CAMBRI DGE CITY	Č	0				194. 10
	961 WELL BEING	C	0	_ ~			194. 11
	962 ACTIVATE HEALTH EMPLOYER CLINIC 963 NEW CASTLE PEDIATRICS		0	0	_		194. 12 194. 13
1	1964 HENRY COUNTY RADIOLOGY			ő			194. 14
194. 15 07	965 HENRY COUNTY ANESTHESI OLOGY	C	0	0	0		194. 15
	1966 NEW CASTLE IMMEDICATE CARE & FAMILY	C) 0	0	0	0	194. 16
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202. 00	Cost to be allocated (per Wkst. B,	6, 759, 612	738, 808	1, 362, 209	1, 252, 491	475, 206	
202 00	Part I)	20.00(00)	1 047450	/ 0540/0	144 0074 :-	0 (00707	202 22
203. 00	Unit cost multiplier (Wkst. B, Part I) 30. 286086	1. 047418	6. 254863	141. 237145	0. 692707	1203.00

Health Financial Systems	HE	ENRY COUNTY MEM	IORI AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICA	L BASIS		Provi der CO		Period: From 01/01/2022	Worksheet B-1	
					To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
Cost Center Desc	ri pti on	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE	(PATI ENT	(FTE'S)	
		(SQUARE	(POUNDS OF	FEET)	DAYS)		
		FEET)	LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
204.00 Cost to be alloc	ated (per Wkst. B,	1, 531, 783	101, 918	69, 42	7 216, 358	59, 798	204.00
Part II)							
205.00 Unit cost multip	olier (Wkst. B, Part	6. 863073	0. 144491	0. 31878	8 24. 397609	0. 087167	205.00
11)							
206.00 NAHE adjustment	amount to be allocated						206.00
(per Wkst. B-2)							
207.00 NAHE unit cost n	nultiplier (Wkst. D,						207.00
Parts III and IV	<i>'</i>)						
		•		•	•	•	•

		ENRY COUNTY MEMO				u of Form CMS-2552-1
COST ALL	OCATION - STATISTICAL BASIS		Provi der CO	Fr	eriod: com 01/01/2022	Worksheet B-1
				To	12/31/2022	Date/Time Prepared: 5/26/2023 3:03 pm
	Cost Center Description	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	
		N	SUPPLY	REQUIS.)	LI BRARY	
		(DI RECT NRSI NG HRS)	(COSTED REQUIS.)		(TIME SPENT)	
		13. 00	14. 00	15. 00	16. 00	
	ENERAL SERVICE COST CENTERS DIOONEW CAP REL COSTS-BLDG & FIXT					1.00
	D200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL					4.00
	0700 OPERATION OF PLANT					5. 00 7. 00
	0800 LAUNDRY & LINEN SERVICE					8. 00
	0900 HOUSEKEEPI NG 1000 DI ETARY					9. 00 10. 00
	1100 CAFETERI A					11.00
	1300 NURSING ADMINISTRATION	711, 129	15 174 541			13.00
	1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY	0	15, 174, 541 25, 881	100		14. 00 15. 00
16. 00 01	1600 MEDICAL RECORDS & LIBRARY	0	2, 804	0	3, 112	16.00
	IPATIENT ROUTINE SERVICE COST CENTERS BOOO ADULTS & PEDIATRICS	134, 090	376, 390	0	207	30.00
	B100 INTENSIVE CARE UNIT	34, 920	139, 552	Ö	112	31.00
	1300 NURSERY	11, 876	29, 373	0	76	43.00
	ICILLARY SERVICE COST CENTERS 5000 OPERATING ROOM	110, 696	951, 576	0	590	50.00
	DELIVERY ROOM & LABOR ROOM	3, 631	8, 981	0	0	52.00
	5400 RADI OLOGY-DI AGNOSTI C 5700 CT SCAN	0	152, 335 129, 733	0	479 141	54. 00 57. 00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	o	19, 995	Ö	33	58.00
	5900 CARDI AC CATHETERI ZATI ON	0	0	0	0	59.00
	5000 LABORATORY 5001 BLOOD LABORATORY	0	2, 373, 878 0	0	505 0	60. 00 60. 01
65.00 06	5500 RESPI RATORY THERAPY	0	41, 653	0	31	65.00
	6600 PHYSI CAL THERAPY 6700 OCCUPATI ONAL THERAPY	0	38, 659 1, 366	0	21 3	66. 00 67. 00
	5800 SPEECH PATHOLOGY	o	156	0	1	68.00
	5900 ELECTROCARDI OLOGY	0	65, 706	0	27	69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7200 IMPL. DEV. CHARGED TO PATIENT	0	380, 335 9, 721, 825	0	72 149	71. 00 72. 00
73.00 07	7300 DRUGS CHARGED TO PATIENTS	ō	0	100	0	73.00
	B950 CARDI AC REHAB ITPATI ENT SERVI CE COST CENTERS	5, 809	5, 423	0	3	76. 00
	8800 RURAL HEALTH CLINIC	120, 918	51, 618	0	17	88.00
	RURAL HEALTH CLINIC II	194, 600	116, 160	0	85	88. 01
	B802 RURAL HEALTH CLINIC III	23, 569 71, 020	27, 615 470, 967	0	0 548	88. 02 91. 00
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART)	,				92. 00
	THER REIMBURSABLE COST CENTERS DIOO HOME HEALTH AGENCY	O	29, 795	0	8	101.00
SP	PECIAL PURPOSE COST CENTERS	<u> </u>	27, 770	5	<u> </u>	101.00
	INTEREST EXPENSE IOO					113. 00 114. 00
	1600 HOSPI CE	0	12, 765	0	4	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	711, 129	15, 174, 541	100	3, 112	118. 00
	ONREIMBURSABLE COST CENTERS OOOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	l	O	0	0	190. 00
192. 00 19	P200 PHYSICIANS' PRIVATE OFFICES	0	0	Ō	0	192.00
	7950 HOSPI TALI ST 7951 RENTAL	0	0	0	0	194. 00 194. 01
	7955 OTHER NONREIMBURSABLE COSTS	0	0	0	0	194. 05
	7956 DR AFZAL	0	0	0	0	194. 06
	7957 PHILLIPS HALL 7958 OB DRS	0	0	0	0	194. 07 194. 08
194. 09 07	7959 THE WATERS	Ö	Ö	Ö	0	194. 09
	7960 CAMBRIDGE CITY 7961 WELL BEING	0	0	0	0	194. 10 194. 11
	7961 WELL BEING 7962 ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	194. 12
194. 13 07	7963 NEW CASTLE PEDIATRICS	0	0	0	0	194. 13
	7964 HENRY COUNTY RADIOLOGY 7965 HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	194. 14 194. 15
	7966 NEW CASTLE IMMEDICATE CARE & FAMILY		0	0	0	194. 16
200.00	Cross Foot Adjustments					200.00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	4, 945, 710	1, 237, 939	5, 236, 732	1, 468, 144	201. 00 202. 00
	Part I) Unit cost multiplier (Wkst. B, Part I)					
203.00		6. 954730		52, 367. 320000	471. 768638	203.00

Health Fina	ncial Systems H	ENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2022 To 12/31/2022		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &		
		N	SUPPLY	REQUI S.)	LI BRARY		
		(DI RECT	(COSTED		(TIME		
		NRSING HRS)	REQUIS.)		SPENT)		
		13. 00	14.00	15.00	16.00		
204. 00	Cost to be allocated (per Wkst. B, Part II)	162, 552	214, 477	79, 41	3 42, 554		204.00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 228583	0. 014134	794. 13000	0 13. 674165		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	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0030	Peri od: From 01/01/2022	Worksheet C Part I

				From 01/01/2022 o 12/31/2022	Part Date/Time Pre	
			20011		5/26/2023 3: 0	13 pm
		litle	XVIII	Hospi tal	PPS	
Cook Cooker Books at the	Tatal Cast	Th	Tatal Casta	Costs	T-+-1 C+-	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B, Part I,	Adj .		Di sal I owance		
	col . 26)					
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	14, 867, 141		14, 867, 141	0	14, 867, 141	30.00
31. 00 03100 I NTENSI VE CARE UNI T	6, 093, 470		6, 093, 470		6, 093, 470	
43. 00 04300 NURSERY	1, 371, 926	l .	1, 371, 926		1, 371, 926	1
ANCILLARY SERVICE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		.,,,,,,,,	-	.,,	1
50. 00 05000 OPERATING ROOM	10, 224, 591		10, 224, 591	10, 236	10, 234, 827	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	447, 270		447, 270	o	447, 270	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 243, 090		5, 243, 090		5, 243, 090	1
57.00 05700 CT SCAN	909, 085		909, 085	0	909, 085	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	495, 842		495, 842	2 o	495, 842	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		(o	0	59.00
60. 00 06000 LABORATORY	8, 830, 637		8, 830, 637	0	8, 830, 637	60.00
60. 01 06001 BLOOD LABORATORY	0		C	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	2, 814, 966		_, -, ,		2, 814, 966	
66. 00 06600 PHYSI CAL THERAPY	3, 473, 164	0	3, 473, 164		3, 473, 164	1
67. 00 06700 OCCUPATI ONAL THERAPY	405, 521	0	405, 521		405, 521	
68. 00 06800 SPEECH PATHOLOGY	166, 501	0	166, 501		166, 501	
69. 00 06900 ELECTROCARDI OLOGY	552, 945	l e	552, 945		552, 945	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	523, 710	l e	523, 710		523, 710	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	12, 456, 415	l e	12, 456, 415		12, 456, 415	
73. 00 07300 DRUGS CHARGED TO PATIENTS	5, 236, 732		5, 236, 732		5, 236, 732	
76. 00 03950 CARDI AC REHAB	424, 023		424, 023	8 0	424, 023	76. 00
OUTPATIENT SERVICE COST CENTERS	10 102 017		10 102 01/		10 102 01/	00.00
88. 00 08800 RURAL HEALTH CLINIC	10, 193, 016		10, 193, 016			
88. 01 08801 RURAL HEALTH CLINIC II	18, 934, 678	l	18, 934, 678		18, 934, 678	1
88. 02 08802 RURAL HEALTH CLINIC I I	2, 401, 445		2, 401, 445		2, 401, 445	
1 I	8, 882, 735		8, 882, 735		8, 920, 793	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	4, 722, 933		4, 722, 933		4, 722, 933	92.00
101. 00 10100 HOME HEALTH AGENCY	2, 352, 903		2, 352, 903		2, 352, 903	101 00
SPECIAL PURPOSE COST CENTERS	2, 332, 403		2, 332, 903		2, 332, 903	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
116. 00 11600 HOSPI CE	1, 386, 225		1, 386, 225	;	1, 386, 225	
200.00 Subtotal (see instructions)	123, 410, 964				123, 459, 258	
201.00 Less Observation Beds	4, 722, 933	ł	4, 722, 933		4, 722, 933	
202.00 Total (see instructions)	118, 688, 031	l e		1		1
	1,,		,,,		,, 020	,

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0030 Peri od: Worksheet C From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/26/2023 3:03 pm Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio I npati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 11, 972, 177 11, 972, 177 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 5, 706, 447 5, 706, 447 31.00 1, 962, 432 04300 NURSERY 1, 962, 432 43.00 43.00 ANCILLARY SERVICE COST CENTERS 0. 000000 50.00 6, 397, 194 43, 689, 681 50.086.875 0 204137 50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 051, 927 1, 051, 927 0.425191 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 891, 547 21, 023, 052 22, 914, 599 0. 228810 0.000000 54.00 05700 CT SCAN 3, 599, 473 32, 819, 916 36, 419, 389 0.024962 0.000000 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 503, 842 8, 639, 570 0.054229 0.000000 58.00 9, 143, 412 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0.000000 59.00 60.00 06000 LABORATORY 11, 135, 785 42, 974, 907 54, 110, 692 0.163196 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 65.00 06500 RESPIRATORY THERAPY 3, 579, 860 3, 818, 857 7, 398, 717 0.380467 0.000000 65.00 06600 PHYSI CAL THERAPY 5, 676, 758 66.00 742,064 4, 934, 694 0.611822 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 669, 676 0.000000 67.00 872, 316 0.464879 67.00 202,640 06800 SPEECH PATHOLOGY 0.498433 68 00 122, 967 211, 082 334,049 0.000000 68 00 06900 ELECTROCARDI OLOGY 1, 633, 651 5, 672, 963 7, 306, 614 0.075677 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 5, 638, 924 14, 299, 347 19, 938, 271 0.026267 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 6, 709, 208 34, 488, 912 41, 198, 120 0.302354 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 777, 794 7, 848, 754 13, 626, 548 0. 384304 0.000000 73.00 76.00 03950 CARDI AC REHAB 543 794, 929 795, 472 0.533046 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 4, 597, 787 4, 597, 787 88 00 88.01 08801 RURAL HEALTH CLINIC II 0 23, 352, 022 23, 352, 022 88.01 08802 RURAL HEALTH CLINIC III 88.02 0 2, 256, 807 2, 256, 807 88.02 09100 EMERGENCY 8. 732. 787 60, 697, 443 69, 430, 230 0. 127938 0.000000 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 6, 194, 945 92.00 712, 260 5, 482, 685 0.762385 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 2, 277, 208 2, 277, 208 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00

77, 021, 595

77, 021, 595

1, 209, 902

322, 812, 121

322, 812, 121

1, 209, 902

399, 833, 716

399, 833, 716

116.00

200 00

201.00

202.00

116. 00 11600 HOSPI CE

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200 00

201.00

202.00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0030	Period: Worksheet C From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/26/2023 3:03 pm		

Title XVIII Hospital PPS Inpatient Ratio				10 12/31/2022	5/26/2023 3:03 pm	
INPATI ENT ROUTI NE SERVI CE COST CENTERS			Title XVIII	Hospi tal		
11.00	Cost Center Description					
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03000 INTENSI VE CARE UNIT 32.00 04300 NURSERY 34.00 04300 NURSERY 34.00 04300 NURSERY 34.00 05200 DELIVERY ROOM 0.204341 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.425191 54.00 05400 RADIOLOGY-DI AGNOSTI C 0.228810 57.00 05700 CT SCAN 0.024962 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0.054229 59.00 05900 CARDIAC CATHETRIZATI ON 0.000000 60.00 0.6000 LABORATORY 0.163196 60.01 0.6001 BLOOD LABORATORY 0.163196 60.01 0.6001 BLOOD LABORATORY 0.380467 66.00 0.6500 PHYSI CAL THERAPY 0.380467 66.00 0.6600 PHYSI CAL THERAPY 0.44879 68.00 0.6600 PHYSI CAL THERAPY 0.44879 69.00 0.6900 ELECTROCARDI OLOGY 0.498433 69.00 0.6900 ELECTROCARDI OLOGY 0.498433 69.00 0.6900 ELECTROCARDI OLOGY 0.75677 71.00 0.7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.302354 73.00 0.7300 DRUGS CHARGED TO PATIENTS 0.302354 73.00 0.7000 CARDIAC CENTERS 0.0800 RIPLE DEV. CHARGED TO PATIENTS 0.384304 0.533046 0.000000 0.000000 0.000000000 0.00000000						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 0. 425191 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 425191 54. 00 05400 RADIOLOGY-DIAGNOSTIC 0. 228810 57. 00 05700 CT SCAN 0. 024962 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0. 054229 59. 00 05900 CARDIAC CATHETERIZATION 0. 0000000 0. 00000 LABORATORY 0. 163196 0. 000000 0. 00000 LABORATORY 0. 163196 0. 000000 0. 0000 LABORATORY 0. 380467 0. 05000 RESPIRATORY THERAPY 0. 380467 0. 06600 PHYSICAL THERAPY 0. 611822 0. 6600 PHYSICAL THERAPY 0. 464879 0. 06700 OCCUPATIONAL THERAPY 0. 464879 0. 06900 ELECTROCARDIOLOGY 0. 075677 0. 07700 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 026267 0. 07200 MPLD. DEV. CHARGED TO PATIENTS 0. 026267 0. 07200 MPLD. DEV. CHARGED TO PATIENTS 0. 384304 0. 03950 CARDIAC REHAB 0. 533046 0. 00800 NUTRAL ENTRY SERVICE COST CENTERS 0. 08800 RURAL HEALTH CLINIC		11. 00				
31. 00						
43. 00						0. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 50000 OPERATI ING ROOM 0. 204341 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 425191 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 228810 57. 00 05700 CT SCAN 0.024962 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 054229 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 60. 00 06000 LABORATORY 0. 163196 60. 01 06001 BLOOD LABORATORY 0. 380467 66. 00 06500 RESPI RATORY THERAPY 0. 380467 66. 00 06600 PHYSI CAL THERAPY 0. 464879 68. 00 06600 PHYSI CAL THERAPY 0. 464879 68. 00 06600 SPECCH PATHOLOGY 0. 498433 69. 00 06900 ELECTROCARDI OLOGY 0. 498433 69. 00 06900 ELECTROCARDI OLOGY 0. 075677 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 302354 73. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 302354 75. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 384304 00 000 000 CARDI AC REHAB 0. 533046						. 00
50. 00					43.	3. 00
52. 00						
54. 00						0.00
57. 00		1				2. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.054229 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 06.00 06000 LABORATORY 0.163196 0.000000 06.00 06.00 06.00 DESPI RATORY THERAPY 0.0000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000000 0.0000000000 0						1.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 5900 CARDI AC CATHETERI ZATI ON 0.163196 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 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000						7.00
60. 00						3. 00
60. 01						9. 00
65. 00						0.00
66. 00						0. 01
67. 00		1				5.00
68. 00						00
69. 00 06900 ELECTROCARDI OLOGY 0. 075677 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 026267 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0. 302354 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 384304 0. 3950 CARDI AC REHAB 0. 533046 0 0 0 0 0 0 0 0 0						7. 00 3. 00
71. 00						3. 00 9. 00
72. 00						. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 384304 0. 533046 1.		1				2. 00
76. 00 03950 CARDI AC REHAB 0. 533046 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C						3. 00
OUTPATIENT SERVICE COST CENTERS 88. 00 O8800 RURAL HEALTH CLINIC						5. 00
88. 00 08800 RURAL HEALTH CLINIC		0. 555040			70.	. 00
					88	3. 00
	88. 01 08801 RURAL HEALTH CLINIC II					3. 01
						3. 02
		0 128486				. 00
						2. 00
OTHER REIMBURSABLE COST CENTERS	OTHER RELIMBURSABLE COST CENTERS	0.702000			72.	
					101.	. 00
SPECIAL PURPOSE COST CENTERS						
					113.	3. 00
					114.	
					116.	. 00
					200.	
					201.	
					202.	

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

To 12/31/2022 | Date/Time Prepared: 5/26/2023 3:03 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs (from Wkst. Adj Di sal I owance B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 14, 867, 141 14, 867, 141 14, 867, 141 30.00 03100 INTENSIVE CARE UNIT 6, 093, 470 6, 093, 470 0 6, 093, 470 31.00 31.00 1<u>,</u> 371, 926 43.00 04300 NURSERY 1, 371, 926 0 1, 371, 926 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 10, 224, 591 10, 224, 591 10, 236 10, 234, 827 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 447, 270 447, 270 0 447, 270 52.00 05400 RADI OLOGY-DI AGNOSTI C 5, 243, 090 54.00 5. 243. 090 5, 243, 090 54.00 0 909, 085 909, 085 0 909, 085 57.00 05700 CT SCAN 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 495, 842 495, 842 0 495, 842 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 59.00 0 06000 LABORATORY 8, 830, 637 8, 830, 637 8, 830, 637 60.00 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06500 RESPIRATORY THERAPY 2, 814, 966 2, 814, 966 0 2, 814, 966 65.00 65.00 3, 473, 164 66.00 06600 PHYSI CAL THERAPY 3, 473, 164 0 3, 473, 164 0 0 66.00 06700 OCCUPATI ONAL THERAPY C 405.521 405, 521 67.00 405.521 67.00 68.00 06800 SPEECH PATHOLOGY 166, 501 166, 501 166, 501 68.00 06900 ELECTROCARDI OLOGY 552, 945 552, 945 552, 945 69.00 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 523, 710 523, 710 523, 710 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 12, 456, 415 12, 456, 415 12, 456, 415 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 236, 732 5, 236, 732 0 5, 236, 732 73.00 03950 CARDI AC REHAB 76.00 424, 023 424, 023 0 424,023 76.00 OUTPATIENT SERVICE COST CENTERS 10, 193, 016 88.00 08800 RURAL HEALTH CLINIC 10, 193, 016 0 10, 193, 016 88.00 88.01 08801 RURAL HEALTH CLINIC II 18, 934, 678 18, 934, 678 0 18, 934, 678 88.01 88.02 08802 RURAL HEALTH CLINIC III 2, 401, 445 2, 401, 445 ol 2, 401, 445 88.02 09100 EMERGENCY 38, 058 91.00 8, 882, 735 8, 882, 735 8, 920, 793 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 4, 722, 933 4, 722, 933 4, 722, 933 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 2, 352, 903 2, 352, 903 2, 352, 903 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 1, 386, 225 1, 386, 225 1, 386, 225 116. 00 200.00 Subtotal (see instructions) 123, 410, 964 0 123, 410, 964 48, 294 123, 459, 258 200. 00 201.00 Less Observation Beds 4, 722, 933 4, 722, 933 4, 722, 933 201. 00 202.00 Total (see instructions) 118, 688, 031 118, 688, 031 48, 294 118, 736, 325 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0030 Peri od: Worksheet C From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/26/2023 3:03 pm Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 11, 972, 177 11, 972, 177 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 5, 706, 447 5, 706, 447 31.00 1, 962, 432 04300 NURSERY 1, 962, 432 43.00 43.00 ANCILLARY SERVICE COST CENTERS 0. 000000 50.00 6, 397, 194 43, 689, 681 50.086.875 0 204137 50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 051, 927 1, 051, 927 0.425191 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 891, 547 21, 023, 052 22, 914, 599 0. 228810 0.000000 54.00 05700 CT SCAN 3, 599, 473 32, 819, 916 36, 419, 389 0.024962 0.000000 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 503, 842 8, 639, 570 0.054229 0.000000 58.00 9, 143, 412 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0.000000 59.00 60.00 06000 LABORATORY 11, 135, 785 42, 974, 907 54, 110, 692 0.163196 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 65.00 06500 RESPIRATORY THERAPY 3, 579, 860 3, 818, 857 7, 398, 717 0.380467 0.000000 65.00 06600 PHYSI CAL THERAPY 742, 064 5, 676, 758 0.611822 66.00 4, 934, 694 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 669, 676 0.000000 67.00 872, 316 0.464879 67.00 202,640 06800 SPEECH PATHOLOGY 68 00 122, 967 211, 082 334,049 0.498433 0.000000 68 00 06900 ELECTROCARDI OLOGY 1, 633, 651 5, 672, 963 7, 306, 614 0.075677 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 5, 638, 924 14, 299, 347 19, 938, 271 0.026267 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 6, 709, 208 34, 488, 912 41, 198, 120 0.302354 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 777, 794 7, 848, 754 13, 626, 548 0. 384304 0.000000 73.00 76.00 03950 CARDI AC REHAB 543 794, 929 795, 472 0.533046 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 4, 597, 787 4, 597, 787 2.216940 0.000000 88 00 88.01 08801 RURAL HEALTH CLINIC II 0 23, 352, 022 23, 352, 022 0.810837 0.000000 88.01 08802 RURAL HEALTH CLINIC III 88.02 0 2, 256, 807 2, 256, 807 1.064090 0.000000 88.02 09100 EMERGENCY 8. 732. 787 60, 697, 443 69, 430, 230 0. 127938 0.000000 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 6, 194, 945 92.00 712, 260 5, 482, 685 0.762385 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 2, 277, 208 2, 277, 208 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 1, 209, 902 1, 209, 902 116.00

77, 021, 595

77, 021, 595

322, 812, 121

322, 812, 121

399, 833, 716

399, 833, 716

200 00

201.00

202.00

200 00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Health Financial Systems	HENRY COUNTY MEMOR	IAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0030	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/26/2023 3:03 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Innatient			

Cost Center Description				1.5 1.2, 51, 2522	5/26/2023 3: 03 pm
NAPATILENT ROUTI NE SERVICE COST CENTERS 11.00			Title XIX	Hospi tal	
INPATI ENT. ROUTINE. SERVICE. COST CENTERS 30.00 30.00 30100 INTENSIVE CARE UNIT 31.00 31.00 33100 INTENSIVE CARE UNIT 31.00 31.00 33100 INTENSIVE CARE UNIT 31.00 31.00 33100 INTENSIVE SERVICE. COST CENTERS 43.00 31.00 33100 INTENSIVE SERVICE. COST CENTERS 43.00 31.00 3000 OSCODO DEPERATING. ROOM 0.000000 55.00 52.00 05200 OSCODO DEPERATING. ROOM 0.000000 55.00 55.00 05500 OSCODO DEPERATING. ROOM 0.000000 55.00 57.00 05700 CT. SCAN 0.000000 55.00 58.00 05800 RADIOLOGY DIAGNOSTIC 0.000000 55.00 59.00 05900 CARDILAC CATHETERI ZATION 0.000000 55.00 59.00 05900 CARDILAC CATHETERI ZATION 0.000000 59.00 60.01 06001 BLODO LABORATORY 0.000000 65.00 60.01 06001 BLODO LABORATORY 0.000000 65.00 65.00 06500 PRYSICAL THERAPY 0.000000 66.00 66.00 06600 PRYSICAL THERAPY 0.000000 66.00 66.00 06600 PRYSICAL THERAPY 0.000000 66.00 67.00 06700 OSCODO PRYSICAL THERAPY 0.000000 67.00 69.00 06900 SPECCH PATHOLOGY 0.000000 68.00 69.00 06900 SPECCH PATHOLOGY 0.000000 68.00 69.00 06900 SPECCH PATHOLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 07300 DURIS CHARGED TO PATIENTS 0.000000 73.00 73.00 07300 07300 DURIS CHARGED TO PATIENTS 0.000000 73.00 73.00 07300 07300 DURIS CHARGED TO PATIENTS 0.000000 73.00 73.00 07300 07300 DURIS CHARGED TO PATIENTS 0.000000 73.00 73.00 07300 07400 DURIS CHARGED TO PATIENTS 0.000000 73.00 74.00 07100 07100 MEDICAL SUPPLIES CENTERS 0.000000 73.00 75.00 071000 071000 071000 071000 071000 071000 071000 071000 071000 071000 071000 0710000	Cost Center Description	PPS Inpatient			
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30		Ratio			
30. 00 03000 ADULTS & PEDIATRICS 30. 00 43. 00		11. 00			
31.00	INPATIENT ROUTINE SERVICE COST CENTERS				
43.00 04300 NURSERY	30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCILLARY SERVICE COST CENTERS	31. 00 03100 I NTENSI VE CARE UNI T				31.00
50.00 05000 0520	43. 00 04300 NURSERY				43.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.0000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000					
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	50.00 05000 OPERATING ROOM	0. 000000			50.00
57. 00 05700 05700 CT SCAN 0.000000 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 59. 00 05900 CARDI AC CATHETERI ZATION 0.000000 60. 00 06900 LABORATORY 0.000000 60. 00 06000 LABORATORY 0.000000 60. 00	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
58. 00 05800 MACNETIC RESONANCE IMAGING (MRI) 0.000000 59. 00 05900 CARDIAC CATHETERI ZATION 0.000000 59. 00 06000 LABORATORY 0.000000 60. 01 06000 LABORATORY 0.000000 65. 00 06500 RESPIRATORY THERAPY 0.000000 65. 00 06600 PHYSI CAL THERAPY 0.000000 66. 00 06600 PHYSI CAL THERAPY 0.000000 67. 00 06600 PHYSI CAL THERAPY 0.000000 67. 00 06600 PHYSI CAL THERAPY 0.000000 67. 00 06900 CEUPATIONAL THERAPY 0.000000 68. 00 06900 SPECH PATHOLOGY 0.000000 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 071.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 72. 00 072.00 IMPL DEV. CHARGED TO PATIENTS 0.000000 72. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 03950 CARDI AC REHAB 0.000000 74. 00 03950 CARDI AC REHAB 0.000000 88. 01 08800 RURAL HEALTH CLINIC 1 0.000000 88. 01 08800 RURAL HEALTH CLINIC 1 0.000000 88. 01 08800 RURAL HEALTH CLINIC 1 0.000000 88. 01 09100 EMERGENCY 92. 00 09200 0958CRVATION BEDS (NON-DISTINCT PART) 0.000000 92. 00 0958CRVATION REPOSE COST CENTERS 113. 00 114. 00 11400 UTIL IZATION REVIEW-SNF 114. 00 11600 HOSPICE 116. 00 0059CIC 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	57. 00 05700 CT SCAN	0. 000000			57.00
60. 00 06000 LABORATORY 0.000000 60. 01 06001 BLOOD LABORATORY 0.000000 60. 01 06001 BLOOD LABORATORY 0.000000 65. 00 06500 RESPI RATORY THERAPY 0.000000 65. 00 06600 PHYSI CAL THERAPY 0.000000 66. 00 06600 PHYSI CAL THERAPY 0.000000 66. 00 06600 PHYSI CAL THERAPY 0.000000 66. 00 06600 PHYSI CAL THERAPY 0.000000 68. 00 06600 PHYSI CAL THERAPY 0.000000 68. 00 06600 PHYSI CAL THERAPY 0.000000 68. 00 06600 PHYSI CAL THERAPY 0.000000 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
60. 01 06001 06001 06001 06001 06001 06001 060000 060000 060000 060000 060000 060000 060000 0600000 0600000 0600000 0600000 0600000 0600000 0600000 06000000 06000000 06000000 06000000 060000000 0600000000	59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
65. 00 06500 RESPIRATORY THERAPY 0. 000000 66. 00 66. 00 06600 PHYSI CAL THERAPY 0. 000000 66. 00 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 68. 00 06800 SPEECH PATHOLOGY 0. 000000 68. 00 06800 SPEECH PATHOLOGY 0. 000000 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0. 000000 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 03950 CARDI AC REHAB 0. 000000 73. 00 03950 CARDI AC REHAB 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	60. 00 06000 LABORATORY	0. 000000			60.00
66. 00 06600 PHYSI CAL THERAPY 0. 000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 76. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 76. 00 000000 000000 000000 000000 000000	60. 01 06001 BL00D LABORATORY	0. 000000			60. 01
67. 00 06700 OCCUPATI ONAL THERAPY O. 000000 68. 00 68. 00 SPEECH PATHOLOGY O. 000000 68. 00 69. 00 O6900 ELECTROCARDI OLOGY O. 000000 69. 00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS O. 000000 T1. 00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS O. 000000 T2. 00 O7200 IMPL. DEV. CHARGED TO PATIENTS O. 000000 T2. 00 O7300 DRUGS CHARGED TO PATIENTS O. 000000 T3. 00 O7300 DRUGS CHARGED TO PATIENTS O. 000000 T3. 00 O7300 DRUGS CHARGED TO PATIENTS O. 000000 OUTPATIENT SERVICE COST CENTERS O. 0000000 OUTPATIENT SERVICE COST CENTERS O. 000000 S8. 01 O8801 RURAL HEALTH CLINIC I I O. 000000 S8. 01 O8801 RURAL HEALTH CLINIC I I O. 000000 S8. 02 O9100 DEREGENCY O. 000000 O9100 DEREGENCY O. 000000 O9100 DEREGENCY O. 000000 O9100 DEREGENCY O. 000000 O71ERR REI MBURSABLE COST CENTERS O1100 OTHER SET EXPENSE OTHER SET EXPEN	65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 07100 MEDI CAL 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 003950 CARDIAC REHAB 0.000000 76.00 0011PATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.01 88.01 08801 RURAL HEALTH CLINIC III 0.000000 88.01 88.02 08802 RURAL HEALTH CLINIC III 0.000000 88.02 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 085ERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 01101.00 10100 HOME HEALTH AGENCY 9.000000 113.00 114.00 11600 HOME HEALTH AGENCY 114.00 114.00 11400 UTILIZATION REVIEW-SNF 116.00 200.00 Subtotal (see instructions) 200.000	67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
71. 00	68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
72. 00	69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
73. 00 76. 00 03950 CARDIAC REHAB 0. 000000 0UTPATIENT SERVICE COST CENTERS 88. 00 88. 01 08800 RURAL HEALTH CLINIC II 0. 0. 000000 98. 01 99. 00 09100 EMERGENCY 0. 0.000000 99. 00 00100 EMERGENCY 0. 0. 000000 91. 00 00100 EMERGENCY 0. 0. 000000 91. 00 00100 EMERGENCY 0. 0. 000000 91. 00 00100 EMERGENCY 0. 0. 000000 00100 EMERGENCY 0. 0. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
76. 00 03950 CARDI AC REHAB 0. 000000 76. 00 000000 76. 00 000000 88. 00 08800 RURAL HEALTH CLINIC 1 0. 000000 88. 01 08801 RURAL HEALTH CLINIC 11 0. 000000 88. 01 099100 EMERGENCY 0. 000000 99. 00 099200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 000000 99. 00 0000 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF 116. 00 11600 HOSPICE 116. 00 Subtotal (see instructions) 200. 00 00000 9200. 00 00000 00 0000 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
88. 00 08800 RURAL HEALTH CLINIC 0.000000 88. 00 88. 01 08801 RURAL HEALTH CLINIC 1 0.000000 88. 01 88. 02 08802 RURAL HEALTH CLINIC 1 0.000000 88. 02 91. 00 09100 EMERGENCY 0.000000 91. 00 92. 00 09200 08SERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 00 09200 0085ERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 00 101. 00 10100 HOME HEALTH AGENCY 101. 00 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTILIZATION REVIEW-SNF 114. 00 116. 00 11600 HOSPICE 116. 00 200. 00 Subtotal (see instructions) 200. 00	73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
88. 00 88. 01 88. 01 88. 01 88. 02 88. 02 88. 02 91. 00 92. 00 92. 00 07100 MSERVATI ON BEDS (NON-DISTINCT PART) 0.000000 92. 00 07100 ODHER REIMBURSABLE COST CENTERS 101. 00 10100 THER REIMBURSABLE COST CENTERS 113. 00 113.00 114. 00 114. 00 116. 00 116. 00 116. 00 200. 00 Subtotal (see instructions) 88. 00 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	76. 00 03950 CARDI AC REHAB	0. 000000			76.00
88. 01	OUTPATIENT SERVICE COST CENTERS				
88. 02 08802 RURAL HEALTH CLINIC III 0.000000 91.00 991.00 991.00 992.	88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88.00
91. 00	88. 01 08801 RURAL HEALTH CLINIC II	0. 000000			88. 01
92. 00	88. 02 08802 RURAL HEALTH CLINIC III	0. 000000			88. 02
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 116.00 HOSPI CE 116.00 Subtotal (see instructions) 200.00	91. 00 09100 EMERGENCY	0. 000000			91.00
101.00 10100 HOME HEALTH AGENCY	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00	OTHER REIMBURSABLE COST CENTERS				
113.00	101.00 10100 HOME HEALTH AGENCY				101. 00
114.00	SPECIAL PURPOSE COST CENTERS				
116.00 11600 HOSPICE 116.00 200.00 Subtotal (see instructions) 200.00					
200.00 Subtotal (see instructions) 200.00					
201 00 Less Observation Beds 201 00	200.00 Subtotal (see instructions)				
	201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)	202.00 Total (see instructions)				202.00

Health Financial Systems H	ENRY COUNTY MEM	IORIAL HOSPITAL		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		pared:
					5/26/2023 3:0)3 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col . 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 156, 689		1, 156, 689		l	
31.00 INTENSIVE CARE UNIT	434, 327	l e	434, 32		l	
43. 00 NURSERY	103, 110		103, 110		198. 29	
200.00 Total (lines 30 through 199)	1, 694, 126		1, 694, 120	5 12, 642		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2, 446		•			30.00
31.00 INTENSIVE CARE UNIT	505	116, 544				31.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	2, 951	392, 844				200. 00

Health Financial Systems HE	ENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		nared·
				12/01/2022	5/26/2023 3:0	3 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col . 26)		0.00	4 00		
ANOLLI ADV. CEDVI CE COCT. CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	740.000	F0 00/ 07F	0.04405	0 4 000 040	00.777	F0 00
50. 00 05000 OPERATING ROOM	749, 209	50, 086, 875			29, 666	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	49, 255	1, 051, 927			11 500	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	378, 757	22, 914, 599			•	1
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	37, 822 19, 620	36, 419, 389				1
59. 00 05900 CARDI AC CATHETERI ZATI ON	19, 620	9, 143, 412 0	i		430	59.00
60. 00 06000 LABORATORY	339, 312	54, 110, 692			23, 923	
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	339, 312	54, 110, 692 0			23, 923	60.00
65. 00 06500 RESPIRATORY THERAPY	97, 943	7, 398, 717			_	1
66. 00 06600 PHYSI CAL THERAPY	235, 756	5, 676, 758			12, 817	
67. 00 06700 OCCUPATI ONAL THERAPY	8, 398	872, 316				
68. 00 06800 SPEECH PATHOLOGY	6, 846	334, 049				
69. 00 06900 ELECTROCARDI OLOGY	5, 340	7, 306, 614				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 366	19, 938, 271				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	215, 381	41, 198, 120			12, 737	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	79, 413	13, 626, 548				73.00
76. 00 03950 CARDI AC REHAB	24, 923	795, 472				
OUTPATIENT SERVICE COST CENTERS	2 17 720	,,,,,,,,,	0.00.00	., .		70.00
88. 00 08800 RURAL HEALTH CLINIC	202, 906	4, 597, 787	0. 04413	1 0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	451, 434	23, 352, 022			0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	56, 491	2, 256, 807		1 0	0	88. 02
91. 00 09100 EMERGENCY	395, 829	69, 430, 230		1 2, 824, 143	16, 100	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	367, 454	6, 194, 945	0. 05931	5 351, 367	20, 841	92.00
200.00 Total (lines 50 through 199)	3, 731, 455			19, 495, 750	158, 829	200.00

Health Financial Systems	HENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/26/2023 3:0	epared: 03 pm
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
31. 00 03100 INTENSIVE CARE UNIT	o	0		0	0	31.00
43. 00 04300 NURSERY	o	0		0	0	43.00
200.00 Total (lines 30 through 199)	o	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0				
31.00 03100 INTENSIVE CARE UNIT		0	1, 88	0.00	505	
43. 00 04300 NURSERY		0	52	0.00	0	
200.00 Total (lines 30 through 199)		0	12, 64	2	2, 951	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 INTENSIVE CARE UNIT	0					31.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	O					200.00

| Peri od: | Worksheet D | From 01/01/2022 | Part IV | To | 12/31/2022 | Date/Time | Prepared: | From 01/01/2023 | Part | Prepared | THROUGH COSTS

				10 12/31/2022	5/26/2023 3:0	
		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
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
57.00 05700 CT SCAN	0	0		0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
60. 01 06001 BL00D LABORATORY	0	0		0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
76. 00 03950 CARDI AC REHAB	0	0		0 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	0		0	0	88. 02
91. 00 09100 EMERGENCY	0	0		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0030 THROUGH COSTS

						3/20/2023 3.0	o piii
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	0	0	50, 086, 875	l	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	1, 051, 927	l	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	22, 914, 599		
57.00		0	0	0	36, 419, 389	l	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	9, 143, 412		
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0.000000	
60.00	06000 LABORATORY	0	0	0	54, 110, 692	l e	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0.000000	60. 01
65.00	06500 RESPI RATORY THERAPY	0	0	0	7, 398, 717	l e	
66. 00	06600 PHYSI CAL THERAPY	0	0	0	5, 676, 758		
67.00		0	0	0	872, 316		
68. 00	06800 SPEECH PATHOLOGY	0	0	0	334, 049	l e	
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	7, 306, 614	l e	69. 00
71. 00		0	0	0	19, 938, 271	l e	
72.00		0	0	0	41, 198, 120		
73.00		0	0	0	13, 626, 548		
76. 00	03950 CARDI AC REHAB	0	0	0	795, 472	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00		0	0	0	.,,	•	
88. 01	08801 RURAL HEALTH CLINIC II	0	0	0	23, 352, 022	l e	
88. 02	08802 RURAL HEALTH CLINIC III	0	0	0	2, 256, 807		
91. 00	09100 EMERGENCY	0	0	0	69, 430, 230	l e	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	6, 194, 945		
200.00	Total (lines 50 through 199)	0	0	0	376, 705, 550		200. 00

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0030	From 01/01/2022	Worksheet D Part IV Date/Time Prepared: 5/26/2023 3:03 pm

				To	12/31/2022	Date/Time Pre 5/26/2023 3:0	
			Title	XVIII	Hospi tal	PPS	3 piii
	Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	5551 551161 B5551 Pt 1511	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷	3.2	Costs (col. 8	3	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
/	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	1, 983, 319	0	11, 396, 630	0	50.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	1, 446	0	52.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0. 000000	701, 690	0	5, 497, 238	0	54.00
57.00	D5700 CT SCAN	0. 000000	1, 321, 823	0	6, 906, 754	0	57.00
58.00	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	203, 059	0	1, 995, 781	0	58. 00
59.00	D5900 CARDI AC CATHETERI ZATI ON	0. 000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0. 000000	3, 814, 907	0	3, 182, 792	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	0	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0. 000000	1, 147, 935	0	712, 716	0	65.00
	D6600 PHYSI CAL THERAPY	0. 000000	308, 631	0	72, 604	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	86, 409	0	4, 791	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	67, 820	0	4, 028	0	68. 00
69.00	D6900 ELECTROCARDI OLOGY	0. 000000	638, 235	0	1, 665, 762	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 789, 238	0	3, 183, 197	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	2, 436, 374	0	12, 399, 275	0	72.00
73.00	D7300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 820, 800	0	2, 083, 366	0	73.00
76.00	D3950 CARDI AC REHAB	0. 000000	0	0	187, 159	0	76. 00
	DUTPATIENT SERVICE COST CENTERS						
88. 00	D8800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
	08801 RURAL HEALTH CLINIC II	0. 000000	0	0	0	0	88. 01
	08802 RURAL HEALTH CLINIC III	0. 000000	0	0	0	0	88. 02
1	09100 EMERGENCY	0. 000000	2, 824, 143		10, 090, 178	0	91.00
1	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	351, 367	0	1, 441, 909	0	92.00
200.00	Total (lines 50 through 199)		19, 495, 750	0	60, 825, 626	0	200.00

	D VACCUME COST	Provi der C			Workshoot D	2332-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period: From 01/01/2022	Worksheet D Part V	
				o 12/31/2022		nared.
			'	0 12/31/2022	5/26/2023 3:0	
		Ti tl e	xVIII	Hospi tal	PPS	о р
			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.	, and the second	Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2.00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 204137	11, 396, 630	(0	2, 326, 474	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 425191	1, 446		0	615	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 228810	5, 497, 238		0	1, 257, 823	54.00
57. 00 05700 CT SCAN	0. 024962	6, 906, 754	.	0	172, 406	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 054229			0	108, 229	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			0	0	59.00
60. 00 06000 LABORATORY	0. 163196		249	0	519, 419	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			0	0	60.01
65. 00 06500 RESPIRATORY THERAPY	0. 380467	712, 716		0	271, 165	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 611822			0	44, 421	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 464879			0	2, 227	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 498433			0	2,008	
69. 00 06900 ELECTROCARDI OLOGY	0. 075677			0	126, 060	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 026267			0	83, 613	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 302354		1	0	3, 748, 970	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 384304			2, 131		
76. 00 03950 CARDI AC REHAB	0. 533046	187, 159		· ·	99, 764	
OUTPATIENT SERVICE COST CENTERS				1		
88. 00 08800 RURAL HEALTH CLINIC						88. 00
88. 01 08801 RURAL HEALTH CLINIC II						88. 01
88. 02 08802 RURAL HEALTH CLINIC III						88. 02
91. 00 09100 EMERGENCY	0. 127938	10, 090, 178		0	1, 290, 917	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 762385			0	1, 099, 290	
200.00 Subtotal (see instructions)		60, 825, 626		2, 131	11, 954, 047	
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		60, 825, 626	249	2, 131	11, 954, 047	202. 00

				To 12/31/2022	Date/Time Prepared: 5/26/2023 3:03 pm	
		Title	XVIII	Hospi tal	PPS	_
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS			ı			_
50. 00 05000 OPERATI NG ROOM	0	0			50.00	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52. 00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54.00	
57. 00 05700 CT SCAN	0	0			57. 00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0			59.00	
60. 00 06000 LABORATORY	41	0			60.00	
60. 01 06001 BLOOD LABORATORY	0	0			60. 01	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0			65. 00 66. 00	
67. 00 06700 OCCUPATI ONAL THERAPY		0			66.00	
68. 00 06800 SPEECH PATHOLOGY	0	0			68.00	
69. 00 06900 ELECTROCARDI OLOGY	0	0			69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0			71.00	
73. 00 07300 DRUGS CHARGED TO PATTENTS	0	819			73.00	
76. 00 03950 CARDI AC REHAB		019	•		76.00	
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	I.		70.00	,
88. 00 08800 RURAL HEALTH CLINIC					88. 00)
88. 01 08801 RURAL HEALTH CLINIC II					88. 01	
88. 02 08802 RURAL HEALTH CLINIC III					88. 02	
91. 00 09100 EMERGENCY	0	0			91.00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00	
200.00 Subtotal (see instructions)	41	819			200.00	
201.00 Less PBP Clinic Lab. Services-Program	0	0.,			201.00	
Only Charges						
202.00 Net Charges (line 200 - line 201)	41	819			202. 00)

Heal th	Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lieu	u of Form CMS-2	2552-10
COMPU	TATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0030	Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			10, 240	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			10, 240	2.00	
3. 00	.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00	
4.00) Semi-private room days (excluding swing-bed and observation bed days)			6, 987	4.00	
5 00	Total swips had SNE type impatient days (including private room days) through December 21 of the cost			I = 00		

	Cost Center Description	1 00	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATIENT DAYS		1
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10, 240	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10, 240	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)	6, 987	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	Ü	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	2, 446	9.00
7. 00	newborn days) (see instructions)	2, 440	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
	Total nursery days (title V or XIX only)	0	
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	0	16.00
17. 00	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
	reporting period		
19. 00	Medical drate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
20.00	reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	14, 867, 141	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
21.00	7 x line 19)	Ü	21100
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)	_	
	Total swing-bed cost (see instructions)	0 14, 867, 141	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	14, 807, 141	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	1
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	ı
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	ı
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	1
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	14, 867, 141	1
	27 minus line 36)]
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		-
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 451 07	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	1, 451. 87 3, 551, 274	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	3, 331, 274	1
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3, 551, 274	

25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 \times line 20)	0	25. 00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14, 867, 141	27.00
	PRI VATE ROOM DI FFERENTI AL 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		0	30.00
31.00		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00		1	33.00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	1	34.00
35.00		1	35.00
	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	14, 867, 141	37.00
	27 minus line 36)		1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00		1, 451. 87	ı
39. 00		3, 551, 274	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	3, 551, 274	41.00

	Financial Systems HE TATION OF INPATIENT OPERATING COST	NRY COUNTY MEMO	ORIAL HOSPITAL Provider C	CN: 15-0030 P	eri od:	u of Form CMS-2 Worksheet D-1	
					rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/26/2023 3:0	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	T	1. 00	2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	6, 093, 470	1. 882	3, 237. 76	505	1, 635, 069	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					4, 094, 390	1
48. 01	Program inpatient cellular therapy acquisiti				column 1)	0 200 722	
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.C	n)(see instru	ctions)		9, 280, 733	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	392, 844	50.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	158, 829	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				551, 673	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	etist, and	8, 729, 060	53.00
	medical education costs (line 49 minus line	52)					
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00							55.00
55. 01	Permanent adjustment amount per discharge					0. 00	55. 01
55. 02							55.02
56.00	Target amount (line 54 x sum of lines 55, 55			lino E4 minus	lino E2)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget alliount (i i ne so illi nus	THE 53)	0	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	orting period	endi ng 1996,		59.00
	updated and compounded by the market basket)						
60.00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	om prior year	cost report, u	odated by the	0.00	60.00
61. 00	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	he amount by	which operating	g costs (line	0	61.00
	enter zero. (see instructions)						
62. 00 63. 00	1 3 1	ent (see instru	ıcti ons)			0	
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST	(300 1113110	1011 0113)			<u> </u>	00.00
64.00	9 1	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</pre>	ts after Necemb	oer 31 of the	cost reporting	neriad (See	0	65. 00
03.00	instructions)(title XVIII only)	ts arter becenik	der 31 of the	cost reporting	perrou (see	O	05.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	lonly); for	0	66.00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	o costs through	Docombor 21	of the cost re	porting poriod	0	67. 00
07.00	(line 12 x line 19)	e costs till ougi	i becember 51	or the cost re	boi triig perrou	0	07.00
68. 00		e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N					0	07.00
70.00	Skilled nursing facility/other nursing facil						70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line	,	ine 70 ÷ line	2)			71. 00 72. 00
73.00	Medically necessary private room cost applic	,	ı (line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv		•	•			74.00
75.00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B, P	art II, column		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
	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for exces				76		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost limitation	n (line 78 min	us line 79)		80. 00 81. 00
81.00	Inpatient routine service cost per drem immediate Inpatient routine service cost limitation (I)				82.00
83.00	Reasonable inpatient routine service costs (•				83.00
84.00	Program inpatient ancillary services (see in		,				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55. 55	PART IV - COMPUTATION OF OBSERVATION BED PASS		n ough oo)				00.00
	Total observation bed days (see instructions)					87.00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	· line 2)			1, 451. 87	88. 00

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu				u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			4, 722, 933	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	1, 156, 689	14, 867, 141	0. 07780	2 4, 722, 933	367, 454	90.00
91.00 Nursing Program cost	0	14, 867, 141	0.00000	0 4, 722, 933	0	91.00
92.00 Allied health cost	0	14, 867, 141	0.00000	0 4, 722, 933	0	92.00
93.00 All other Medical Education	0	14, 867, 141	0. 00000	0 4, 722, 933	0	93.00

Heal th	Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0030	Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Prep 5/26/2023 3:03	oared: 3 pm
			Ti tle XIX	Hospi tal	Cost	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room day	s and swing-bed day:	s, excluding newborn)		10, 240	1.00
2.00	Inpatient days (including private room day	s, excluding swing-	bed and newborn days)		10, 240	2.00
3. 00						3.00
4.00	Semi-private room days (excluding swing-be	ed and observation b	ed days)		6, 987	4.00

	Cost Center Description	0031	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10, 240	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10, 240	2.00
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)	6, 987	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost		5. 00
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	202	9. 00
7. 00	newborn days) (see instructions)	202	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII 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)	١	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	12.00
40.00	through December 31 of the cost reporting period		40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
	Total nursery days (title V or XIX only)		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
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
17.00	reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
21 00	reporting period	14 0/7 141	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	14, 867, 141 9 0	21. 00 22. 00
22.00	5 x line 17)	,	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	١	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
27, 00	x line 20)		24 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0 14, 867, 141	
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	11,007,111	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
	Pri vate room charges (excluding swing-bed charges)	0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	30. 00 31. 00
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	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)	0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		37.00
	27 minus line 36)	,	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1, 451. 87	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	293, 278	
	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)	293, 278	41. 00

4.00	Semi-private room days (excluding swing-bed and observation bed days)	6, 987	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)	_	
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
0.00	reporting period	0	8. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	8.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	202	9. 00
7. 00	newborn days) (see instructions)	202	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
14.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	14. 00
14. 00 15. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	520	14.00
16. 00	Nursery days (title V or XIX only)	0	16. 00
10.00	SWING BED ADJUSTMENT	U	10.00
17. 00	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
	reporting period		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19.00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	14, 867, 141	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
23. 00	$5 ext{ x line 17}$ Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
23.00	x line 18	U	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
200	7 x line 19)	ŭ.	2 00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14, 867, 141	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Pri vate room charges (excluding swing-bed charges)	0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges)	0. 000000	30. 00 31. 00
32.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)	0.000000	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	14, 867, 141	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 451. 87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	293, 278	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)	293, 278	41.00

MCRI F32 - 19. 1. 175. 2

	ATION OF INPATIENT OPERATING COST	NACT COOLLI MEM	Provider Co	CN: 15-0030 P	eriod: rom 01/01/2022	u of Form CMS-2 Worksheet D-1	
				Т	o 12/31/2022	Date/Time Pre 5/26/2023 3:0	
				e XIX	Hospi tal	Cost	<u> </u>
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
12.00	NUDCEDY (+; +l - V 0 VIV and a)	1. 00	2. 00	3.00	4.00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	1, 371, 926	520	2, 638. 32	0	0	42.00
43.00	INTENSIVE CARE UNIT	6, 093, 470	1, 882	3, 237. 76	0	0	43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46.00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			192, 505	48. 00
48. 01	Program inpatient cellular therapy acquisiti				column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0))(see Instru	ctions)		485, 783	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	m Wkst. D, sum	of Parts I and	0	50.00
F1 00	III) Pass through costs applicable to Program inp	ationt oncillor		som Wko+ D. o	um of Dorto II	0	51.00
51. 00	and IV)	atrent anciria	y services (11	OIII WKSt. D, S	uiii OI Pai tS II	0	31.00
52.00	Total Program excludable cost (sum of lines					0	52.00
53.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	9 1	elated, non-phy	ysician anesth	etist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
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	use only)				0.00	1
56. 00	Target amount (line 54 x sum of lines 55, 55				>	0	56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (I	ine 56 minus	line 53)	0	57. 00 58. 00
59.00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	endi ng 1996,	0.00	
	updated and compounded by the market basket)					0.00	
60. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 tro	om prior year o	cost report, u	odated by the	0. 00	60.00
61. 00	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 w	which operating	g costs (line	0	61.00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	na period (See	0	64.00
	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the o	cost reporting	period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	only); for	0	66.00
47.00	CAH, see instructions	a aaata theawak	Docombon 21	of the cost re	aanting nasiad		47.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	i beceiliber 31 (or the cost re	borting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND ICF/IID	ONLY			
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	,		, ,			70.00
72.00	Program routine service cost (line 9 x line		THE 70 : TIME	2)			72.00
73.00	Medically necessary private room cost applic		7				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
	26, line 45)		(
76.00	Per diem capital related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p					79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost limitation	n (line 78 min	us line 79)		80. 00 81. 00
82.00	Inpatient routine service cost per diem inim Inpatient routine service cost limitation (1)				82.00
83.00	Reasonable inpatient routine service costs (see instruction	•				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		nns)				84. 00 85. 00
86.00	Total Program inpatient operating costs (sum						86.00
	DADT IV COMPUTATION OF OPSEDVATION PED DASS	S THROUGH COST					I
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0.050	87.00

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu				u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		pared: 3 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))			4, 722, 933	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	1, 156, 689	14, 867, 141	0. 07780	2 4, 722, 933	367, 454	90.00
91.00 Nursing Program cost	0	14, 867, 141	0.00000	0 4, 722, 933	0	91.00
92.00 Allied health cost	0	14, 867, 141	0.00000	0 4, 722, 933	0	92.00
93.00 All other Medical Education	O	14, 867, 141	0. 00000	0 4, 722, 933	0	93.00

ealth Financial Systems HENRY COUNTY MEMOR NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	u of Form CMS-: Worksheet D-3	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0030	From 01/01/2022		,
			To 12/31/2022		pared
				5/26/2023 3:0	
	Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	1
				col . 2)	-
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			4 000		4
0. 00 03000 ADULTS & PEDI ATRI CS			4, 339, 071		30.0
1.00 03100 INTENSIVE CARE UNIT			1, 744, 528		31.0
3. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					4
0.00 05000 OPERATING ROOM		0. 2043			
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 4251		l ~	1 '
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2288	· ·		
7. 00 05700 CT SCAN		0. 0249			
8.00 05800 MAGNETI C RESONANCE I MAGING (MRI)		0. 0542			
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000			1
0. 00 06000 LABORATORY		0. 1631		622, 578	
0. 01 06001 BLOOD LABORATORY		0.0000		1	1
5. 00 06500 RESPI RATORY THERAPY		0. 3804			
6. 00 06600 PHYSI CAL THERAPY		0. 6118		188, 827	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 4648			
8. 00 06800 SPEECH PATHOLOGY		0. 4984	· ·	•	
9. 00 06900 ELECTROCARDI OLOGY		0. 0756			
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0262			
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 3023		•	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3843			73.0
6. 00 03950 CARDI AC REHAB		0. 5330	46 0	0	76.
OUTPATIENT SERVICE COST CENTERS		0.0000	20		4
8. 00 08800 RURAL HEALTH CLINIC		0.0000		0	1
8. 01 08801 RURAL HEALTH CLINIC II		0.0000		0	
8.02 08802 RURAL HEALTH CLINIC III		0.0000		0	
1. 00 09100 EMERGENCY		0. 1284			
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7623			
Total (sum of lines 50 through 94 and 96 through 98)	(11)		19, 495, 750		
01.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0	l	201.
02.00 Net charges (line 200 minus line 201)		1	19, 495, 750		202.

	Financial Systems H ENT ANCILLARY SERVICE COST APPORTIONMENT	ENRY COUNTY MEMORIAL HOSPITAL Provider C		Peri od:	u of Form CMS-2 Worksheet D-3	
				From 01/01/2022 To 12/31/2022		narod:
				10 12/31/2022	5/26/2023 3:0	
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
					col . 2)	
	LABOTI FAT DOUTLAG OFFICE OFFICE		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			210 510	<u> </u>	
30.00	03000 ADULTS & PEDIATRICS			213, 519		30.00
31.00	03100 NTENSIVE CARE UNIT			123, 912	l	31.00
43.00	04300 NURSERY			227, 800		43.00
FO 00	ANCILLARY SERVICE COST CENTERS		0.20412	202.050	41 /15	
50.00	05000 OPERATING ROOM		0. 20413	•	41, 615 0	
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC		0. 42519			52. 00 54. 00
57.00	05700 CT SCAN		0. 22881 0. 02496	•	5, 961 1, 449	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.05422			58.00
59. 00	05900 CARDIAC CATHETERIZATION		0.00000	•	0 200	59.00
60.00	06000 LABORATORY		0. 16319			60.00
60. 00	06001 BL00D LABORATORY		0. 00000	•	1	60.00
65. 00	06500 RESPIRATORY THERAPY		0. 38046		1	65.00
66. 00	06600 PHYSI CAL THERAPY		0. 61182	•		
67. 00	06700 OCCUPATI ONAL THERAPY		0. 46487	•		1
68.00	06800 SPEECH PATHOLOGY		0. 49843		l e	
69. 00	06900 ELECTROCARDI OLOGY		0. 07567	•	l	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 02626	•		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT		0. 30235		0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 38430		1	
	03950 CARDI AC REHAB		0. 53304	•		76.00
2. 20	OUTPATIENT SERVICE COST CENTERS			122		
88. 00	08800 RURAL HEALTH CLINIC		2. 21694	10 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II		0. 81083		0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III		1. 06409	0 0	0	88. 02
01 00	00100 EMEDGENCY		0 40700	170 000	00.00/	01 00

0. 127938 0. 762385

1, 075, 388

91. 00 92. 00

201. 00 202. 00

22, 006 0

192, 505 200. 00

91. 00 | 09100 | EMERGENCY | 92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART)

200.00

201. 00 202. 00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0030	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/26/2023 3:03 pm

	Title XVIII Hospital	5/26/2023 3: 0: PPS	3 pm
		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 October 1 (see instructions)	3, 965, 545	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1, 472, 117	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octob 1 (see instructions)		1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	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 18, 450 796	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 instructions)	0 39. 08	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending	on 0.00	5. 00
5. 01 6. 00	or before 12/31/1996. (see instructions) FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap f	0. 00 or 0. 00	5. 01 6. 00
6. 26	new programs in accordance with 42 CFR 413.79(e) Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 o		6. 26
7. 00 7. 01	the CAA 2021 (see instructions) MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If th	0. 00 e 0. 00	7. 00 7. 01
7. 02	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural	0.00	7. 02
8. 00	track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the coreport straddles July 1, 2011, see instructions.		8. 01
8. 02 8. 21	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see	0.00	8. 02 8. 21
9. 00	instructions) Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or		9.00
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records	0.00	
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)	0.00	11. 00 12. 00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year ended on or after September 30, 199 otherwise enter zero.		13. 00 14. 00
15. 00 16. 00		1	15. 00 16. 00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count		17. 00 18. 00
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)	0. 000000 0. 000000	
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)	0. 000000 0	21. 00 22. 00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23. 00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0. 00 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	26. 00 27. 00
28. 00 28. 01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)	0	28. 00 28. 01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29. 00 29. 01
30.00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2. 60	
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31 Allowable dispreparations to share percentage (see instructions)	22. 68	
აა. UU 	Allowable disproportionate share percentage (see instructions)	ı 7. 92 	33.00

Heal th	Financial Systems HENRY COUNTY MEI	MORLAL HOSPITAL	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0030	Peri od:	Worksheet E	1002 10
			From 01/01/2022 To 12/31/2022	Part A Date/Time Pre	pared.
				5/26/2023 3:0	
		Title XVIII	Hospi tal	PPS	
				1. 00	
34.00	Disproportionate share adjustment (see instructions)			107, 666	34.00
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Payment Adjustment		1.00	2.00	
35. 00	Total uncompensated care amount (see instructions)		0	0	35. 00
35. 01	Factor 3 (see instructions)		0.000000000	0. 000000000	35. 01
35. 02	Hospital UCP, including supplemental UCP (If line 34 is ze (see instructions)	ero, enter zero on this iin	e) 590, 026	630, 624	35. 02
35. 03	1.	UCP (see instructions)	441, 307	158, 952	35. 03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03		600, 259		36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges (see instructions)	discharges (lines 40 thro	ugh 46) 0		40. 00
41. 00	Total ESRD Medicare discharges (see instructions)		0		41.00
41. 01	Total ESRD Medicare covered and paid discharges (see instr		0		41. 01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qualitate Total Medicare ESRD inpatient days (see instructions)	ualify for adjustment)	0.00		42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 dividence of the stay to one week)	ded by line 41 divided by 7	0. 000000		44.00
	days)	3			
45.00			0.00		45.00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line Subtotal (see instructions)	2 41.01)	6, 164, 833		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH	H, small rural hospitals	6, 928, 158		48. 00
	only. (see instructions)				
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructi	ons)		6, 737, 327	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I			409, 241	
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Direct graduate medical education payment (from Wkst. E-4,			0	51. 00 52. 00
53. 00	Nursing and Allied Health Managed Care payment	Title 47 See Thisti detroils)	•	ő	53.00
54.00	Special add-on payments for new technologies			152, 039	
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lir	20, 60)		0 0	54. 01 55. 00
55. 00	Cellular therapy acquisition cost (see instructions)	ie 09)		0	55. 00
56. 00	Cost of physicians' services in a teaching hospital (see i	ntructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt		through 35).	0	57.00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, F Total (sum of amounts on lines 49 through 58)	Pt. IV, col. II line 200)		0 7, 298, 607	58. 00 59. 00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 mi	nus line 60)		7, 298, 607	
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			738, 524 10, 503	
	Allowable bad debts (see instructions)			28, 572	
65.00	Adjusted reimbursable bad debts (see instructions)			18, 572	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		21, 433	
67. 00 68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f	for applicable to MS-DRGs (see instructions)	6, 568, 152 0	67. 00 68. 00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 9	• •		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70. 50 70. 75	Rural Community Hospital Demonstration Project (§410A Demo N95 respirator payment adjustment amount (see instructions	· · · · · · · · · · · · · · · · · · ·	instructions)	0	70. 50 70. 75
70. 73	Demonstration payment adjustment amount (see instructions)	7		0	70.73
70. 88	SCH or MDH volume decrease adjustment (contractor use only	/)		0	70. 88
70.89				_	70.89
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions HSP bonus payment HRR adjustment amount (see instructions)	7		0 -6, 294	
70. 92	Bundled Model 1 discount amount (see instructions)			0,271	
70. 93	, ,			0	70. 93
70. 94 70. 95	HRR adjustment amount (see instructions) Recovery of accelerated depreciation			-59, 861 0	70. 94 70. 95
, 0. 75	1.000.0.3 or accordinated appropriation			•	, , , , , ,

	Financial Systems HENRY COUNTY MEMORI				u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der Co	JN: 15-0030	Peri od: From 01/01/2022	Worksheet E Part A	
				To 12/31/2022	Date/Time Pre	pared:
		Ti +Lo	XVIII	Hospi tal	5/26/2023 3: 0 PPS	3 pm
		IIIIe		(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		2022	628, 700	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		2023	201, 501	70. 97
	the corresponding federal year for the period ending on or af	ter 10/1)				
70. 98	Low Volume Payment-3				0	70. 98
	1				0	70. 99
		69 & 70)			7, 332, 198	
	Sequestration adjustment (see instructions)				92, 385	71. 01
	Demonstration payment adjustment amount after sequestration				0	
	Sequestration adjustment-PARHM or CHART pass-throughs					71.03
	Interim payments				7, 075, 693	
	Interim payments-PARHM or CHART					72. 01
					0	73.00
73. 01	Tentative settlement-PARHM or CHART (for contractor use only					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0	2, 72, and			164, 120	74.00
74 01	73) Balance due provider/program-PARHM or CHART (see instructions	`				74 01
	Protested amounts (nonallowable cost report items) in accorda				104, 074	74. 01
75.00	CMS Pub. 15-2, chapter 1, §115.2	nce with			104, 074	/5.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		•		!	
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.00
	plus 2.04 (see instructions)					
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruc	tions)			0	93.00
94.00	The rate used to calculate the time value of money (see instr	uctions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)				0	95.00
96. 00	Time value of money for capital related expenses (see instruc	tions)			0	96.00
				Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount					
	HSP bonus amount (see instructions)			428, 194	144, 300	100. 00
	HVBP Adjustment for HSP Bonus Payment					

	Prior to 10/1	On/After 10/1	
	1.00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	428, 194	144, 300	100.00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	1. 0000000000	1. 0000000000	
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0. 9853	1. 0000	
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	-6, 294	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00 Is this the first year of the current 5-year demonstration period under the 21st			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.			
Cost Reimbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
202.00 Medicare discharges (see instructions)			202. 00
203.00 Case-mix adjustment factor (see instructions)			203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of the curren period)	t 5-year demonst	tration	
204.00 Medicare target amount			204.00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement	<u>'</u>		1
207.00 Program reimbursement under the §410A Demonstration (see instructions)			207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)			209. 00
210.00 Reserved for future use			210.00
211.00 Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparision of PPS versus Cost Reimbursement			
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00 Low-volume adjustment (see instructions)			213.00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218.00
(line 212 minus line 213) (see instructions)			

Provider CCN: 15-0030

Peri od:

From 01/01/2022

LOW VOLUME CALCULATION EXHIBIT 4

Part A Exhibit 4

Date/Time Prepared: 5/26/2023 3:03 pm 12/31/2022 Title XVIII Hospi tal W/S E, Part A Amounts (from Period Prior Total (Col 2 Pre/Post Peri od Entitlement to 10/01 On/After through 4) I i ne E. Part A) 10/01 0 1.00 2.00 3.00 4.00 5.00 1.00 DRG amounts other than outlier 1. 00 1.00 payments 1.01 DRG amounts other than outlier 1.01 3, 965, 545 1.01 3, 965, 545 0 3, 965, 545 payments for discharges occurring prior to October 1 1.02 DRG amounts other than outlier 1.02 1, 472, 117 1, 472, 117 1, 472, 117 1.02 payments for discharges occurring on or after October 1 03 DRG for Federal specific 1.03 0 \cap 1.03 operating payment for Model 4 BPCI occurring prior to October 1 DRG for Federal specific 1 04 1 04 0 1.04 operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for 2.00 2.00 discharges (see instructions) Outlier payments for 2.01 2.02 C 0 2.01 discharges for Model 4 BPCI Outlier payments for 18, 450 18, 450 18, 450 2.02 2.03 2.02 discharges occurring prior to October 1 (see instructions) Outlier payments for 796 796 2.03 796 2.04 2.03 discharges occurring on or after October 1 (see instructions) Operating outlier 3.00 2.01 0 3.00 0 reconciliation 4.00 Managed care simulated 3.00 C 4.00 payments Indirect Medical Education Adjustment Amount from Worksheet E, Part 21. 00 0.000000 0.000000 0.000000 0.000000 5 00 5 00 A, line 21 (see instructions) 6.00 IME payment adjustment (see 22.00 0 C 0 0 6.00 instructions) 6.01 IME payment adjustment for 22.01 0 0 0 6.01 managed care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor 27. 00 0. 000000 0.000000 0.000000 0.000000 7.00 (see instructions) IME adjustment (see 8.00 28.00 0 8.00 0 instructions) IME payment adjustment add on 8.01 28.01 0 8.01 for managed care (see instructions) 9.00 Total IME payment (sum of 29.00 0 0 9.00 lines 6 and 8) 9 01 Total IME payment for managed 29 01 0 9.01 care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 0.0792 10.00 Allowable disproportionate 33.00 0.07920.07920.0792share percentage (see instructions) Disproporti onate share 11.00 34.00 107, 666 78, 518 29, 148 107, 666 11.00 adjustment (see instructions) Unc<u>ompensated care payments</u> 441, 307 158, 952 11.01 36, 00 600, 259 600, 259 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment 46. 00 12.00 (see instructions) 13.00 Subtotal (see instructions) 47.00 6. 164. 833 4, 503, 820 1, 661, 013 6, 164, 833 13 00 14.00 Hospital specific payments 48.00 6, 928, 158 5, 085, 534 1, 842, 624 6, 928, 158 14.00 (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient 6, 737, 327 15.00 4, 940, 106 15.00 49.00 6, 737, 327 1, 797, 221 operating costs (see instructions)

Health Financial Systems	HE	NRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
LOW VOLUME CALCULATION EXHIBIT 4			Provi der Co		Period: From 01/01/2022 To 12/31/2022		pared:
			Title	XVIII	Hospi tal	PPS	
	W/S E. Part A	Amounts (from	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	409, 241	0	300, 47	3 108, 768	409, 241	16. 00
17.00 Special add-on payments for new technologies	54.00	152, 039	0	106, 59	9 45, 440	152, 039	
17.01 Net organ aquisition cost 17.02 Credits received from manufacturers for replaced	68. 00	0	0		0 0	0	17. 01 17. 02
devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	0	18. 00
19. 00 SUBTOTAL			0	5, 347, 17	8 1, 951, 429	7, 298, 607	10 00
17. 00 SUBTOTAL	W/S L, line	(Amounts from L)	0	3,347,17	1, 731, 427	7, 270, 007	17.00
	0	1. 00	2. 00	3.00	4. 00	5. 00	
20.00 Capital DRG other than outlier		407, 375	0	298, 92		407, 375	20.00
20.01 Model 4 BPCI Capital DRG other than outlier		0	0		0 0	0	20. 01
21.00 Capital DRG outlier payments 21.01 Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	1, 866 0	0	1, 54	7 319 0 0	1, 866 0	
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0. 0000		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0. 000	0. 0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11. 00	0	0		0 0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	409, 241	0	300, 47	3 108, 768	409, 241	26. 00
	W/S E, Part A	(Amounts to					
	line	E, Part A)					
	0	1. 00	2. 00	3.00	4. 00	5. 00	
27.00 Low volume adjustment factor 28.00 Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 11757 628, 70		628, 700	27. 00 28. 00
Pt. A, line) 29.00 Low volume adjustment (transfer amount to Wkst. E,	70. 97				201, 501	201, 501	29. 00
Pt. A, line) 100.00 Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Provider CCN: 15-0030

Peri od:

From 01/01/2022

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Part A Exhibit 5

Date/Time Prepared: 5/26/2023 3:03 pm 12/31/2022 Title XVIII Hospi tal Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 3.965.545 3, 965, 545 3, 965, 545 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 1 02 1, 472, 117 1, 472, 117 1, 472, 117 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 18, 450 18, 450 2.02 Outlier payments for discharges occurring 2.03 18, 450 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 796 796 796 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 0 6.00 0 6.01 IME payment adjustment for managed care (see 22.01 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8.00 IME adjustment (see instructions) 28.00 0 0 8.00 0 IME payment adjustment add on for managed 0 28 01 C 0 8 01 8 01 0 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 9.00 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 0.0792 0.0792 0.0792 (see instructions) 11.00 Di sproporti onate share adjustment (see 34.00 107,666 78, 518 29, 148 107, 666 11.00 instructions) Uncompensa<u>ted care payments</u> 158, 952 600, 259 11.01 36 00 600, 259 441.307 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 4, 503, 820 13.00 Subtotal (see instructions) 6, 164, 833 1, 661, 013 6, 164, 833 13.00 14.00 Hospital specific payments (completed by SCH 48.00 6, 928, 158 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15 00 49 00 6 737 327 5 076 314 1, 661, 013 6, 737, 327 15 00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 409, 241 300, 473 108, 768 409, 241 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 152, 039 106, 599 45, 440 152, 039 17.00 Net organ acquisition cost 17.01 17.01 17.02 Credits received from manufacturers for 68.00 0 0 Λ 17.02 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 18.00 amount (see instructions) 19.00 SUBTOTAL 5, 483, 386 7, 298, 607 19. 00 1, 815, 221

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

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10							
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 3:0	pared:	
		Title	XVIII	Hospi tal	PPS		
	Wkst. L, line	(Amt. from Wkst. L)					
	0	1. 00	2. 00	3. 00	4. 00		
20.00 Capital DRG other than outlier	1. 00	407, 375	298, 92	6 108, 449	407, 375	20.00	
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		o o	0	20. 01	
21.00 Capital DRG outlier payments	2. 00	1, 866	1, 54	7 319	1, 866	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. 0000	0. 000	0. 0000	i	24. 00	
25.00 Disproportionate share adjustment (see instructions)	11. 00	0		0	0	25. 00	
26.00 Total prospective capital payments (see instructions)	12. 00	409, 241	300, 47	3 108, 768	409, 241	26. 00	
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)					
	0	1. 00	2. 00	3. 00	4. 00		
27.00 28.00 Low volume adjustment prior to October 1 29.00 Low volume adjustment on or after October 1 30.00 HVBP payment adjustment (see instructions)	70. 96 70. 97 70. 93	628, 700 201, 501 0	•	0 201, 501 0 0	0	29. 00 30. 00	
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	00.0.	
31.00 HRR adjustment (see instructions) 31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 94 70. 91	-59, 861 -6, 294	-59, 86 -6, 29		-59, 861 -6, 294	31. 00 31. 01	
					(Amt. to Wkst. E, Pt. A)		
	0	1. 00	2. 00	3. 00	4. 00		
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0	0	32.00	
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00	

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0030	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 3:03 pm

		Title XVIII	Hospi tal	5/26/2023 3: 0: PPS	3 piii
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			860	1. 00
2. 00	Medical and other services (see Fristractions)	ons)		11, 954, 047	2. 00
3. 00	OPPS payments	··· ·· /		11, 005, 845	3. 00
4.00	Outlier payment (see instructions)			18, 343	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructi	ons)		0. 000	5.00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0. 00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)			0.00	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			860	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			2 380	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		2, 300	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)	, ,,		2, 380	
	Customary charges			·	
15. 00	Aggregate amount actually collected from patients liable for pay				15.00
16. 00	Amounts that would have been realized from patients liable for p	payment for services o	n a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			2, 380	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	1, 520	
	instructions)		, ,		
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
21 00	instructions)			0/0	21 00
21. 00 22. 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			860 0	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			11, 024, 188	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	
26. 00	Deductibles and Coinsurance amounts relating to amount on line 2	•		1, 709, 675	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu instructions)	is the sum of lines 22	and 23] (see	9, 315, 373	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	÷ 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	29.00
30.00	Subtotal (sum of lines 27 through 29)			9, 315, 373	30.00
31.00	Primary payer payments			2, 804	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	•1		9, 312, 569	32. 00
33 00	Composite rate ESRD (from Wkst. I-5, line 11))		0	33. 00
34. 00	Allowable bad debts (see instructions)			143, 193	
35.00	Adjusted reimbursable bad debts (see instructions)			93, 075	
36.00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		131, 190	36.00
	Subtotal (see instructions)			9, 405, 644	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			-52 0	38. 00 39. 00
39. 00 39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			U	39. 00 39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced	d devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			9, 405, 696	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			118, 512 0	40. 01 40. 02
40. 03	Sequestration adjustment-PARHM or CHART pass-throughs			J	40. 03
41.00	Interim payments			9, 311, 734	
41. 01	Interim payments-PARHM or CHART				41.01
42.00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM or CHART (for contractor use only)			24 550	42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-24, 550	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2.	chapter 1.	0	
	§115. 2			_	
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions)			0 00	91. 00 92. 00
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			0	
				•	

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0030	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Pr 5/26/2023 3:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(200.00

Health Financial Systems HENRY CANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 15-0030

			1	0 12/31/2022	5/26/2023 3:0	
		Title	· XVIII	Hospi tal	PPS	о р
			it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
4 00	I -	1. 00	2.00	3. 00	4. 00	4 00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		7, 075, 693 0		9, 191, 161 0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER		1 0	12/31/2022	120, 573	3.01
3. 02	ADJUSTINIENTS TO TROVIDER			12/31/2022	120, 373	3.02
3. 03			l			3. 03
3. 04			l o		0	3.04
3. 05			Ö		0	
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	
3. 52			0		0	
3. 53			0		0	
3. 54			0		0	0.0.
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		120, 573	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7, 075, 693		9, 311, 734	4.00
F 00	TO BE COMPLETED BY CONTRACTOR	l	ı			- 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					İ
5. 01	TENTATI VE TO PROVI DER		0		0	5.01
5.02			0		0	5. 02
5. 03			0		0	5.03
	Provider to Program	· · · · · · · · · · · · · · · · · · ·				
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	
5. 52	Cubtatal (aum af lines 5 01 5 40 minus aum a Cilines		0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		164, 120		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		24, 550	
7. 00	Total Medicare program liability (see instructions)		7, 239, 813		9, 287, 184	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8.00

Heal th	Financial Systems HENRY COUNTY MEMOR	I AL HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0030	Peri od: From 01/01/2022	Worksheet E-7 Part II	I
	To 12/31/2022 Date/Time Pre				
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	. S-3, Pt. I col. 15 lin	ie 14		1.00
2.00 Medicare days (see instructions)					2. 00 3. 00
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	Total inpatient days (see instructions)				4.00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 I				6. 00 7. 00
7. 00	7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I				
8. 00	Calculation of the HIT incentive payment (see instructions)				8.00
9. 00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	line 31) (see instructio	ns)		32.00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Li eu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0030	From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2023 3:03 pm

PART VII - CALCILLATION OF REINBURGENETY - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				o 12/31/2022	Date/lime Pre 5/26/2023 3:0	
Inpatient Outpatient Outp			Title XIX	Hospi tal		о рііі
PART VII - CALCULATION OF RETURBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
PART VII - CALCULATION OF BET INSURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
COMPUTATION OF NET COST OF COVERED SERVICES		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	/ICES FOR TITLES V OR XI		2.00	
Inpatient hospital/SNF/ME services			TODE TON TITLES TON AL	02 020		1
Medical and other services	1. 00			485. 783		1.00
Organ acquisition (certified transplant programs only)				,	0	
Subtotal (sum of lines 1, 2 and 3)				0		1
Inpatt ent primary payer payments				485, 783	0	1
0.0 0.0		1		0		
Subtotal (line 4 less sum of lines 5 and 6)					0	
Reasonable Charges 8.00 Routine service charges 1,075,388 0 9.00	7.00			485, 783	0	7.00
Routine service charges		COMPUTATION OF LESSER OF COST OR CHARGES				1
9.00 Ancillary service charges 1,075,388 0 9.00		Reasonabl e Charges]
10.00 Organ acquisition charges, net of revenue 0 10.0	8.00	Routi ne servi ce charges		565, 231		8.00
11.00 Incentive from target amount computation 11.00 11.00 12.00 1	9.00	Ancillary service charges		1, 075, 388	0	9.00
12.00 Cotat reasonable charges (sum of lines 8 through 11) 1,640,619 0 12.00 13.00 13.00 14.00 15.00 14.00 15.00 1	10.00	Organ acquisition charges, net of revenue		0		10.00
CUSTOMARY_CHARGES	11.00	Incentive from target amount computation		0		11.00
13.00 Amount actually collected from patients liable for payment for services on a charge 0 0 0 13.00	12.00	Total reasonable charges (sum of lines 8 through 11)		1, 640, 619	0	12.00
basis						
14. 00 Amounts that would have been realized from patients Liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413. 13(e) 0.000000 15.00 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 15.00 16.00 17.00 Total customary charges (see instructions) 1.640,619 0.16.00 17.00 18.00 19	13.00		services on a charge	0	0	13. 00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 16.00 Ratio of line 13 to line 14 (not to exceed 1.00000) 17.00 Excess of customary charges (see instructions) 18.00 Excess of customary charges (see instructions) 18.00 Excess of reasonable cost over reasonable cost (complete only if line 16 exceeds 1.154, 836						
15. 00	14. 00			0	0	14.00
16. 00 Total customary charges (see instructions) 1,640,619 0 16. 00 17. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1,154,836 0 17. 00 11 10 10 10 10 10 10	45.00		2 CFR §413.13(e)			45.00
17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1,154,836 0 17.00		,				
18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 0 18.00 16) (see instructions) 0 0 19.00 100			1611	,	-	
18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 16) (see instructions) 0	17.00		y it line 16 exceeds	1, 154, 836	0	17.00
16) (see instructions)	10 00		if line 4 exceeds line		0	10 00
19.00 Interns and Residents (see instructions) 0 0 19.00 20.00 2	18.00		y II II'ne 4 exceeds II'ne	٩	U	18.00
20.00 Cost of physicians' services in a teaching hospital (see instructions) Cost of covered services (enter the lesser of line 4 or line 16) 485,783 O 21.00	10 00			0	0	10 00
21.00			ictions)			
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.		1		-	-	
22. 00 Other than outlier payments 0 0 22. 00 23. 00 Outlier payments 0 0 23. 00 24. 00 Program capit al payments 0 24. 00 25. 00 Capit al exception payments (see instructions) 0 25. 00 26. 00 Routine and Ancillary service other pass through costs 0 0 25. 00 27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 0 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 485, 783 0 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18) 0 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 485, 783 0 31. 00 32. 00 Deductibles 0 0 33. 00 0 0 33. 00 33. 00 Coinsurance 0 0 33. 00 0 0 33. 00 34. 00 Allowable bad debts (see instructions)	21.00			 	0	21.00
23.00 Outlier payments 0 0 23.00 24.00 Program capital payments 0 24.00 25.00 Capital exception payments (see instructions) 0 25.00 26.00 Routine and Ancillary service other pass through costs 0 0 25.00 27.00 Subtotal (sum of lines 22 through 26) 0 0 27.00 28.00 Customary charges (title V or XIX PPS covered services only) 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 485,783 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 485,783 0 31.00 32.00 Deductibles 0 0 32.00 33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 485,783 0 36.00	22 00		sompreted for the provid		0	22 00
24. 00 Program capital payments 0 24. 00 25. 00 Capital exception payments (see instructions) 0 25. 00 26. 00 Routine and Ancillary service other pass through costs 0 0 26. 00 27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 485, 783 0 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 0 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 485, 783 0 31. 00 32. 00 Deductible s 0 0 32. 00 33. 00 Coinsurance 0 0 32. 00 34. 00 Allowable bad debts (see instructions) 0 34. 00 35. 00 Utilization review 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 485, 783 0 36. 00 37. 00 <		1 3				
25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT COMPUTATION OF REIMBURSEMENT SETTLEMENT Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 485,783 48					ŭ	
26.00 Routine and Ancillary service other pass through costs 0 0 26.00 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 1 titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 36.00 Utilization review 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 485,783 4		1 3 4 4 1 4 1 4 1 4 1 4 1 4 1 4 1 4 1 4		o		25. 00
27. 00 Subtotal (sum of lines 22 through 26) 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 485, 783 0 31. 00 31. 00 Deductibles 0 0 0 32. 00 33. 00 Coi nsurance 0 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 485, 783 0 36. 00 38. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 485, 783 0 36. 00 38. 00 Subtotal (line 36 ± line 37) 485, 783 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 485, 783 0 40. 00 41. 00 Inter im payments 616, 996 0 41. 00 42. 00 Bal ance due provider/program (line 40 minus line 41) -131, 213 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0				O	0	1
28.00 Customary charges (title V or XIX PPS covered services only) 7 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 8 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 8 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 8 Coinsurance 9 OOO 32.00 10 OOO 33.00 11 OOO 34.00 12 OOO 34.00 13 OOO 35.00 14 OOO 36.00 15 OOO 30.00 16 OOO 30.00 17 OOO 30.00 18 OOO 30.0	27.00	, ,		o	0	27.00
29.00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles Coinsurance Allowable bad debts (see instructions) Allowable bad debts (see instructions) Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Therefore a subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Therefore a subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39) Total amount payable to the provider (sum of lines 38 and 39) Total anount payable to the provider (sum of lines 38 and 39) Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, O 29.00 29.00 485,783 O 30.00 30.00 30.00 485,783 O 36.00 39.00 485,783 O 40.00 42.00 Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, O 43.00		,		o	0	28. 00
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 485,783 485,783 0 38.00 49.00 Total amount payable to the provider (sum of lines 38 and 39) 485,783 0 40.00 41.00 Interim payments 486,783 0 40.00 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	29.00			485, 783	0	29. 00
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 485,783 485,783 0 38.00 40.00 Interim payments 486,783 0 40.00 41.00 Interim payments 616,996 41.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00		COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
32. 00 Deductibles 0 0 32. 00 33. 00 Coinsurance 0 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 485, 783 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 485, 783 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 485, 783 0 40. 00 41. 00 Interim payments 616, 996 0 41. 00 42. 00 Balance due provider/program (line 40 minus line 41) -131, 213 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00	30.00			0	0	30.00
33. 00 Coinsurance 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 34. 00 35. 00 Utilization review 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 485, 783 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 485, 783 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 485, 783 0 40. 00 41. 00 Interim payments 616, 996 0 41. 00 42. 00 Balance due provider/program (line 40 minus line 41) -131, 213 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00	31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		485, 783	0	31.00
34.00 Allowable bad debts (see instructions)	32.00	Deducti bl es		0	0	32.00
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 485,783 0 38.00 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 35.00 35.00 36.00 37.00 38.00 38.00 39.00	33.00	Coinsurance		0	0	33.00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 485,783 485,783 0 36.00 38.00 39.00 40.00 Interim payments 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	34.00	Allowable bad debts (see instructions)		0	0	34.00
37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 485, 783 0 40. 00 41. 00 Interim payments 616, 996 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 37. 00 38. 00 485, 783 0 40. 00 41. 00 42. 00 43. 00	35.00	Utilization review		0		35.00
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 485, 783 0 40.00 44.00 41.00 42.00 43.00	36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	485, 783	0	36.00
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 39.00 485, 783 616, 996 0 41.00 -131, 213 0 42.00 0 43.00				0	-	
40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 40.00 41.00 41.00 -131,213 0 42.00 43.00				485, 783	0	
41.00 Interim payments 616,996 42.00 Balance due provider/program (line 40 minus line 41) 63.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				0		
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00		, , , , , , , , , , , , , , , , , , , ,			-	
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00		1			-	1
Ichonton 1 Alle 1	43.00		ce with CMS Pub 15-2,	0	0	43.00
Chapter 1, 9115.2		chapter 1, §115.2		1		I

Heal th	Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu o								
OUTLI E	OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 15-0030 Period: W								
	From 01/01/2022 To 12/31/2022 D 5								
		Title XVIII		PPS					
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 instr	ructions)		0	3.00				
4.00	Capital outlier reconciliation adjustment amount (see instruc	ctions)		0	4.00				
5.00	The rate used to calculate the time value of money (see instr	ructions)		0.00	5.00				
6.00	Time value of money for operating expenses (see instructions))		0	6.00				
7.00	Time value of money for capital related expenses (see instruc	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 only)

Provi der CCN: 15-0030

Peri od: Worksheet G From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/26/2023 3:03 pm

		General Fund	Speci fi c	Endowment	Plant Fund	3 pili
			Purpose Fund	Fund		
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1. 00	Cash on hand in banks	13, 867, 645	0	ol	0	1.00
2.00	Temporary investments	0	0	О	0	2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4. 00	Accounts recei vable	18, 091, 336	0	0	0	4.00
5. 00	Other receivable	0	0	0	0	5.00
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	1, 299, 274	0	U O	0	6. 00 7. 00
8. 00	Prepaid expenses	2, 437, 245	0	0	0	8.00
9. 00	Other current assets	-11, 514, 015	Ö	o	0	9. 00
10.00	Due from other funds	107, 788, 171	0	o	0	10.00
11. 00	Total current assets (sum of lines 1-10)	131, 969, 656	0	0	0	11.00
10.00	FI XED ASSETS	1/ 000		ام	0	10.00
12. 00 13. 00	Land improvements	46, 000 1, 533, 097	0	0	0	12. 00 13. 00
14. 00	Accumulated depreciation	-1, 076, 593	0	0	0	14.00
15. 00	Bui I di ngs	41, 605, 998	-1	ő	0	15. 00
16.00	Accumulated depreciation	-32, 138, 400	0	o	0	16.00
17.00	Leasehold improvements	2, 304, 083	0	o	0	17.00
18. 00	Accumulated depreciation	-1, 223, 327	0	0	0	18.00
19.00	Fixed equipment	22, 480, 880	0	0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	-13, 092, 649	0	U O	0	20. 00 21. 00
22. 00	Accumulated depreciation	0	0	0	0	22.00
23. 00	Major movable equipment	39, 155, 328	Ö	ő	0	23. 00
24. 00	Accumul ated depreciation	-27, 997, 771	0	o	0	24.00
25.00	Mi nor equi pment depreciable	0	0	o	0	25. 00
26.00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00 29. 00	Accumulated depreciation	0	0	0	0	28. 00 29. 00
30.00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	31, 596, 646	0	0	0	30.00
30.00	OTHER ASSETS	31, 370, 040	J			30.00
31.00	Investments	18, 437, 341	0	0	0	31.00
32.00	Deposits on Leases	0	0	o	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7, 962, 882	0	0	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	26, 400, 223 189, 966, 525	0	0	0	35. 00 36. 00
30.00	CURRENT LIABILITIES	104, 400, 323	<u> </u>	<u> </u>	0	30.00
37.00	Accounts payable	2, 632, 621	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7, 712, 625	0	o	0	38. 00
39.00	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	1, 100, 484	0	0	0	40.00
41.00	Deferred income	0	0	O	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	0	0	0	0	42. 00 43. 00
44. 00	Other current liabilities	79, 747, 812	0	0	0	44.00
	Total current liabilities (sum of lines 37 thru 44)	91, 193, 542	1	o	0	
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	0	0	0	0	47.00
48. 00	Unsecured Loans	0	0	0	0	48.00
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	10, 348, 475 10, 348, 475		U O	0	49. 00 50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	101, 542, 017		o	0	51.00
011.00	CAPITAL ACCOUNTS	101/012/01/	<u> </u>	<u> </u>		000
52.00	General fund balance	88, 424, 508				52. 00
53.00	Specific purpose fund		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 57. 00	Governing body created - endowment fund balance			۷	0	56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	57. 00 58. 00
55. 50	replacement, and expansion				O	33.00
59.00	Total fund balances (sum of lines 52 thru 58)	88, 424, 508	0	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	189, 966, 525	0	o	0	60.00
	[59]	1		l		

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10 Peri od: From 01/01/2022 Provi der CCN: 15-0030 Worksheet G-1

					To	12/31/2022	Date/Time Pre 5/26/2023 3:0	
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fund	
		1.00	2.00	2.00		4.00	F 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0 0 0	2. 00 88, 166, 035 258, 473 88, 424, 508		0 0 0 0 0	4.00	5. 00 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 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	0 0 0 0 0	0 88, 424, 508 0 88, 424, 508		0 0 0 0 0	0 0	0 0 0 0 0	13. 00 14. 00 15. 00 16. 00
	sheet (line 11 minus line 18)	Endowment	PI ant	Fund				
		Fund						
1.00		6. 00	7. 00	8. 00				1.00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0			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	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	0	0 0 0 0 0		0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19. 00	sheet (line 11 minus line 18)	ď			U			19. 00

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

			То	12/31/2022	Date/Time Prep 5/26/2023 3:03	
	Cost Center Description		Inpatient	Outpati ent	Total	J pili
	3331 331131 33331 1 21 311		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				0.00	
	General Inpatient Routine Services					
1.00	Hospi tal		12, 546, 577		12, 546, 577	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		0	5.00
6.00	Swing bed - NF		0		0	6.00
7. 00	SKILLED NURSING FACILITY					7.00
8. 00	NURSI NG FACILITY					8. 00
9.00	OTHER LONG TERM CARE		10 511 533		40 544 533	9.00
10. 00	Total general inpatient care services (sum of lines 1-9)		12, 546, 577		12, 546, 577	10.00
11 00	Intensive Care Type Inpatient Hospital Services		(004 07/		/ 004 07/	11 00
11.00	INTENSIVE CARE UNIT		6, 004, 976		6, 004, 976	11.00
12.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT					12. 00 13. 00
13. 00 14. 00	SURGICAL INTENSIVE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	ines	6, 004, 976		6, 004, 976	16. 00
10.00	11-15)	11163	0,004,970		0,004,770	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		18, 551, 553		18, 551, 553	17. 00
18. 00	Ancillary services		46, 421, 220	231, 978, 831	278, 400, 051	18.00
19.00	Outpati ent servi ces		8, 527, 720	60, 660, 666	69, 188, 386	19.00
20.00	RURAL HEALTH CLINIC		0	4, 597, 787	4, 597, 787	20.00
20. 01	RURAL HEALTH CLINIC II		0	23, 352, 022	23, 352, 022	20.01
20.02	RURAL HEALTH CLINIC III		0	2, 256, 807	2, 256, 807	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY			2, 277, 208	2, 277, 208	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		0	1, 209, 902	1, 209, 902	26.00
27. 00	NON-REI MBURSEABLE		2, 161	15, 096, 538	15, 098, 699	27. 00
27. 01	PRO FEES	34/1	3, 445, 371	7, 648, 383	11, 093, 754	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	O WKST.	76, 948, 025	349, 078, 144	426, 026, 169	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			140, 037, 418		29. 00
30.00	ADD (SPECIFY)		0	140, 037, 410		30.00
31. 00	(or correspond		o			31.00
32. 00			Ö			32.00
33.00			O			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			o		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38. 00			0			38.00
39. 00			0			39.00
40.00			0			40.00
41.00			0			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)	(transfer		140, 037, 418		43.00
	to Wkst. G-3, line 4)	1			I	

	Financial Systems HENRY COUNTY MEMO			u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-0030	Peri od:	Worksheet G-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, I	ine 28)		426, 026, 169	1.00
2.00	Less contractual allowances and discounts on patients' acco	ounts		288, 275, 904	2.00
3.00	Net patient revenues (line 1 minus line 2)	137, 750, 265	3.00		
4.00	Less total operating expenses (from Wkst. G-2, Part II, lin	140, 037, 418	4.00		
5.00	Net income from service to patients (line 3 minus line 4)	-2, 287, 153	5.00		
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			-3, 295, 130	7.00
8.00	Revenues from telephone and other miscellaneous communicati	on services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients	·		0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER OPERATING INCOME			5, 264, 626	24.00
	NON-OPERATING INCOME			323, 214	
	COVI D-19 PHE Fundi ng			252, 916	1
	Total other income (our of lines (24)			2 545 424	

2, 545, 626

258, 473

25.00

26.00 0 27.00 0 28.00 258, 473 29. 00

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

0

1, 483, 117

-12, 091

-41, 023

0

1, 471, 026

23.50

24.00

Tel emedi ci ne

24.00 Total (sum of lines 1-23)

23.50

0

0

0

0

0

0

0

0

0

0

1, 471, 026

18.00

19.00

20.00

21.00

22.00

23.00

23.50

24.00

Clinic

Health Promotion Activities

Home Delivered Meals Program

Total (sum of lines 1-23)

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

18.00

19.00 20.00

21.00

22.00

23.00

23.50

24.00

Heal th	Financial Systems	HE	NRY COUNTY MEN	MORIAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
COST AL	COST ALLOCATION - HHA STATISTICAL BASIS					Period: From 01/01/2022	Worksheet H-1 Part II	
						To 12/31/2022		pared: 3 pm
				Home Health Agency I	PPS			
		Capital Rel	ated Costs					
		BI dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportatic n (MILEAGE)	Reconciliatio n	Administrativ e & General (ACCUM. COST)	
		1. 00	2. 00	3.00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	T 0				1 0		1.00
	Fixtures							

Provi der CCN: 15-0030 HHA CCN: 15-7430 Peri od: Worksheet H-2
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/26/2023 3:03 pm

PPS

Home Health

						Agency I	PPS	
			CAPI TAL REI	ATED COSTS		Agency 1		
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	
		0	1. 00	2.00	4. 00	4A	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 21. 00	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0 803, 043 537, 072 86, 556 6, 536 0 37, 819 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	426, 727 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	426, 727 803, 043 537, 072 86, 556 6, 536 0 37, 819 0 0 0 0 0 0 0	82, 133 154, 564 103, 372 16, 660 1, 258	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50
	of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	
		7. 00	8. 00	9. 00	10.00	11. 00	N 13. 00	
16. 00 17. 00 18. 00 19. 00	Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	69, 355 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14, 324 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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

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

	ATLON OF CENERAL CERVICE COCTE		TEDE		N. 15 0000		W	
ALLUC	ATION OF GENERAL SERVICE COSTS	IO HHA COSI CEN	IIEKS	Provider CC		Period: From 01/01/2022 To 12/31/2022		pared:
						Home Health	PPS	<u> 5 piii </u>
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Agency I Intern & Residents Cost & Post Stepdown	Subtotal	
		14. 00	15. 00	16. 00	24.00	Adjustments 25.00	26. 00	
14. 00 15. 00 16. 00 17. 00 18. 00	Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	2, 431 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. UU	3, 774 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	598, 74 957, 60 640, 44 103, 21 7, 79 45, 09	4 0 77 0 4 0 6 0 0 0 18 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	598, 744 957, 607 640, 444 103, 216 7, 794 0 45, 098 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 18. 00 19. 50
	Cost Center Description	Allocated HHA A&G (see Part	Total HHA Costs					
		27. 00	28. 00					
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	326, 859 218, 601 35, 231 2, 660 0 15, 393 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 284, 466 859, 045 138, 447 10, 454 0 60, 491 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00 21.00

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

BASIS HHA CCN: 15-7430 Home Health

					Home Health	PPS	
	CAPITAL REL	ATED COSTS			Agency I		
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	1 00	2.00		5Δ	5.00	7 00	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	4.00 1,232,079 0 0 0 0 0 0 0 0 0 0 0 0 0		803, 043 537, 072 86, 556 6, 536 0 37, 819 0 0 0 0 0 0	7.00 2,290 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	22.00
	8. 00	9. 00	10. 00	11. 00	13. 00	14. 00	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			29, 795 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21.00

	Financial Systems		NRY COUNTY MEMOR		45 0000		u of Form CMS-	
	ATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	IERS STATESTICAL	Provider CCN:	15-0030	Peri od: From 01/01/2022	Worksheet H-2 Part II	<u>'</u>
BASIS				HHA CCN:	15-7430	To 12/31/2022		pared:
							5/26/2023 3:0	
						Home Health	PPS	
						Agency I		
	Cost Center Description	PHARMACY	MEDI CAL					
		(COSTED	RECORDS &					
		REQUIS.)	LI BRARY					
			(TIME					
		45.00	SPENT)					
1 00	In Indiana de Constant	15. 00	16. 00					1.00
1.00	Administrative and General	0	8					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology Medical Social Services	0	0					5.00
6. 00 7. 00	Home Health Aide	0	0					6. 00 7. 00
7. 00 8. 00	1	0	0					8.00
9. 00	Supplies (see instructions)	0	0					9.00
10.00	Drugs DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13. 00	Pri vate Duty Nursing	0	0					13.00
14. 00	Clinic	0	0					14.00
15. 00	Health Promotion Activities	0	0					15.00
16. 00	Day Care Program	0	0					16.00
17. 00	Home Delivered Meals Program	0	0					17. 00
18.00	Homemaker Service	0	0					18.00
19. 00	All Others (specify)	0	0					19.00
19. 50	Tel emedi ci ne	0	0					19.50
20.00	Total (sum of lines 1-19)	0	8					20.00
21.00	Total cost to be allocated	0	3, 774					21.00
	Unit cost multiplier	0. 000000	471. 750000					22.00

Heal th	Financial Systems	HE	ENRY COUNTY MEM	ORIAL HOSPITAL	_	In Lie	u of Form CMS-2	2552-10
	TONMENT OF PATIENT SERVICE COS				CN: 15-0030	Peri od:	Worksheet H-3	
				HHA CCN:	15-7430	From 01/01/2022 To 12/31/2022	Part I Date/Time Pre 5/26/2023 3:0	
				Titl€	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	Costs (from Wkst. H-2,	Ancillary Costs (from	Costs (cols. 1 + 2)		Per Visit (col. 3 ÷	
		20, 11110	Part I)	Part II)	1 1 2)		col . 4)	
	T	0	1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF T	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
	COST LIMITATION Cost Per Visit Computation							<u> </u>
1. 00	Skilled Nursing Care	2.00	1, 284, 466		1, 284, 46	4, 050	317. 15	1.00
2.00	Physi cal Therapy	3.00	859, 045	C	859, 04	4, 559	188. 43	2.00
3.00	Occupational Therapy	4. 00		C	,		219. 41	3.00
4.00	Speech Pathology	5.00		C	10, 45		106. 67	1
5.00	Medical Social Services	6.00	1		40.40	0 0	0.00	
6. 00 7. 00	Home Health Aide Total (sum of lines 1-6)	7.00	60, 491 2, 352, 903	C	60, 49 2, 352, 90	·	38. 70	6. 00 7. 00
7.00	Total (sum of fiftes 1-0)		2, 332, 703		Program Visi			7.00
					og.a v.o.	.0		
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					to Dodustibles	Deductibles		
					Deducti bl es Coi nsurance			
		0	1.00	2. 00	3. 00	4.00	5. 00	
	Limitation Cost Computation							
8. 00	Skilled Nursing Care		17140	C		6		8. 00
8. 01	Skilled Nursing Care		34620	C		30		8. 01
8. 02 9. 00	Skilled Nursing Care	•	99915 17140	C		36 13		8. 02 9. 00
9. 00	Physical Therapy Physical Therapy		34620	C		55		9.00
9. 02	Physical Therapy		99915	C				9. 02
10.00	Occupational Therapy		17140	C		0		10.00
10. 01	Occupational Therapy		34620	C) 2	22		10. 01
10. 02	Occupational Therapy		99915	C				10. 02
11.00	Speech Pathology		17140	C	1	0		11.00
11. 01 11. 02	Speech Pathology Speech Pathology		34620 99915	C	1	0 32		11. 01 11. 02
12. 00	Medical Social Services		17140	C		0		12.00
12. 01	Medical Social Services		34620	C	•	Ö		12. 01
12.02	Medical Social Services		99915	C		0		12. 02
13.00	Home Health Aide		17140	C		0		13.00
13. 01	Home Heal th Ai de		34620	C		22		13. 01
13. 02	1		99915	C				13.02
14.00	Total (sum of lines 8-13) Cost Center Description	From Wkst.	Facility	Shared	3,35 Total HHA		Ratio (col. 3	14. 00
	cost center bescription	H-2 Part I,	Costs (from	Ancillary	Costs (cols.		÷ col . 4)	
		col. 28, line		Costs (from	1 + 2)	Records)		
			Part I)	Part II)	·			
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
15. 00	Supplies and Drugs Cost Comput Cost of Medical Supplies	ations 8.00	ol	C	<u>, </u>	0 0	0. 000000	1 1 5 00
	Cost of Drugs	9.00		C	1			
10.00	COST OF Drugs	7.00	Program Visits		Cost of	0	0. 000000	10.00
			3		Servi ces			
			Par	t B]	Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles & Coinsurance	Coi nsurance		Deductibles & Coinsurance	Coi nsurance	
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION							
	Cost Per Visit Computation	1			1			
1.00	Skilled Nursing Care	0	1, 072			0 339, 985		1.00
2. 00 3. 00	Physical Therapy Occupational Therapy	0	1, 359 242			0 256, 076 0 53, 097		2. 00 3. 00
4. 00	Speech Pathology		32			0 3, 413		4.00
5. 00	Medical Social Services	0	0			0 0		5.00
6. 00	Home Health Aide	0	645			0 24, 962		6.00
7.00	Total (sum of lines 1-6)	0	3, 350		1	0 677, 533		7. 00

	Financial Systems IONMENT OF PATIENT SERVICE COS		NRY COUNTY MEM	ORIAL HOSPITAL Provider CO HHA CCN:		Period: From 01/01/2022 To 12/31/2022 Home Health		Bepared:
	Cost Center Description					Agency I		
	·	6. 00	7. 00	8.00	9. 00	10. 00	11.00	
8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00	Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide							8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 02 11. 00 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00
		Progr	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	t B Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Supplies and Drugs Cost Comput	6.00 ations	7. 00	8. 00	9. 00	10. 00	11.00	
15. 00 16. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00	15, 547 0			0 0		
	PART I - COMPUTATION OF LESSER		PROGRAM COST, A	AGGREGATE OF TH	HE PROGRAM L	MITATION COST, O	DR BENEFICIARY	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	339, 985 256, 076 53, 097 3, 413 0 24, 962 677, 533						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
	Limitation Cost Computation	12.00						
11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02	Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide							8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00

Health Financial Systems HENRY COUNTY MEM				IORI AL HOSPI TAI	_	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF PATIENT SERVICE COSTS				Provider C		Peri od:	Worksheet H-3		
				HHA CCN:	15-7430	From 01/01/2022 To 12/31/2022		pared:	
							5/26/2023 3:0		
						Home Health PPS			
						Agency I			
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to			
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as			
		9, line		provi der	Costs (col.	1 Indicated			
				records)	x col. 2)				
		0	1. 00	2. 00	3.00	4. 00			
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS									
1.00	Physi cal Therapy	66.00	0. 611822	(0 col. 2, line 2	. 00	1.00	
2.00	Occupational Therapy	67.00	0. 464879	(0 col. 2, line 3	. 00	2.00	
3.00	Speech Pathology	68.00	0. 498433	(0 col. 2, line 4	. 00	3.00	
4.00	Cost of Medical Supplies	71.00	0. 026267	(0 col. 2, line 1	5. 00	4.00	
5.00	Cost of Drugs	73.00	0. 384304	(0 col. 2, line 1	6. 00	5.00	

ealth Financial Systems HENRY COUNTY MEMORIAL HOSPI CALCULATION OF HHA REIMBURSEMENT SETTLEMENT Provide			CN: 15-0030	Peri od:	u of Form CMS-2552 Worksheet H-4	
ECCENTION OF THIS RETWINDORSEMENT SETTLEMENT		HHA CCN:	15-7430	From 01/01/2022 To 12/31/2022	Part I-II Date/Time Pre	pare
		Title	XVIII	Home Health	5/26/2023 3: 0 PPS	3 pii
				Agency I		
			Part A	Not Subject	t B Subject to	
			Tart A	to	Deductibles &	
				Deductibles &	Coi nsurance	
			1 00	Coi nsurance	2.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST		1. 00	2.00	3. 00	
	Reasonable Cost of Part A & Part B Services					
00	Reasonable cost of services (see instructions)			0 0	0	
00	Total charges			0 0	0	2
00	Customary Charges Amount actually collected from patients liable for payment for	or sorvices		0 0	0	3
,0	on a charge basis (from your records)	or services		0	U	`
00	Amount that would have been realized from patients liable for	payment		0 0	0	4
	for services on a charge basis had such payment been made in					
0	with 42 CFR §413.13(b)		0.0000	0 00000	0.000000	
00	Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions)		0.0000	0.00000	0. 000000 0	1
00	Excess of total customary charges over total reasonable cost	(complete		0 0	0	
	only if line 6 exceeds line 1)					
00	Excess of reasonable cost over customary charges (complete or	nly if line		0 0	0	8
00	1 exceeds line 6) Primary payer amounts			0 0	0	9
,0	Titiliary payer amounts			Part A	Part B	
				Servi ces	Servi ces	
	DADT II. COMPUTATION OF THE DELINDUPCEMENT CETTLEMENT			1. 00	2. 00	
00	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)			0	0	10
00	Total PPS Reimbursement - Full Episodes without Outliers			0	367, 791	
00	Total PPS Reimbursement - Full Episodes with Outliers			0	80, 815	
00	Total PPS Reimbursement - LUPA Episodes			0	5, 581	13
00	Total PPS Reimbursement - PEP Episodes			0	2, 413	
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	5		0	30, 583	
00	Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments			0	0	10
00	DME Payments			0	0	1
00	Oxygen Payments			0	0	1
00	Prosthetic and Orthotic Payments			0	0	
00	Part B deductibles billed to Medicare patients (exclude coins	surance)			0	1
	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)			0	487, 183 0	
	Subtotal (line 22 minus line 23)			0	487, 183	
	Coinsurance billed to program patients (from your records)				0	
	Net cost (line 24 minus line 25)			0	487, 183	
	Allowable bad debts (from your records)					27
	Adjusted reimbursable bad debts (see instructions)				0	
00	Allowable bad debts for dual eligible (see instructions) Total costs - current cost reporting period (see instructions	-1		0	407 102	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	5)		0	487, 183 0	
50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	0	
99	Demonstration payment adjustment amount before sequestration	-,		0	0	30
00	Subtotal (see instructions)			0	487, 183	
01	Sequestration adjustment (see instructions)			0	6, 647	
00	Demonstration payment adjustment amount after sequestration	actructions		0	0	
02	Sequestration adjustment for non-claims based amounts (see in	istructions)		0	490 534	
75	Interim nayments (see instructions)					
75 00	Interim payments (see instructions) Tentative settlement (for contractor use only)			0	480, 534 0	
75 00	Interim payments (see instructions) Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 31.0	02, 31.75, 32	2, and 33)	0	460, 534 0 2	33

TO PROGRAM BENEFICIARIES

HHA CCN: 15-7430

				Home Health	PPS	<u> </u>
			. 5	Agency I	1	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3.00	4. 00	
1.00	Total interim payments paid to provider			0	480, 534	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		Г	_1	1	
3. 01				0	0	3. 01
3. 02 3. 03				0	0	3. 02 3. 03
3. 03				0		3. 03
3. 05				0	0	3. 05
	Provi der to Program				_	
3.50				0	0	3.50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3.53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 54 3. 99
3. 77	3. 50-3. 98)			o e		3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)			0	480, 534	4.00
	(transfer to Wkst. H-4, Part II, column as appropriate,					
	line 32)					
F 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5. 00
5. 00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01				0	0	5. 01
5. 02				0	0	5. 02
5. 03				0	0	5. 03
E E0	Provider to Program			0	0	5. 50
5. 50 5. 51				0		5. 50 5. 51
5. 52				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			o	l ol	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)				_	
6. 01	SETTLEMENT TO PROVIDER			0	2	6. 01
6. 02 7. 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)			0	0 480, 536	6. 02 7. 00
7.00	Total medicale program frability (see Histructions)		L	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8.00

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0 70.00

0 71.00

920, 978 100. 00

0 62.00

65.00

68.00

PALLIATIVE RADIATION THERAPY**

NONREI MBURSABLE COST CENTERS

OTHER PATIENT CARE SERVICES (SPECIFY) **

HOSPICE/PALLIATIVE MEDICINE FELLOWS*

PALLIATIVE CHEMOTHERAPY**

BEREAVEMENT PROGRAM *

PALLIATIVE CARE PROGRAM*

OTHER PHYSICIAN SERVICES*

TELEHEALTH/TELEMONI TORI NG*

71.00 OTHER NONREIMBURSABLE (SPECIFY)*

NURSING FACILITY ROOM & BOARD*

VOLUNTEER PROGRAM *

RESIDENTIAL CARE*

FUNDRAI SI NG*

ADVERTI SI NG*

THRIFT STORE*

44.00

45.00

46.00

60.00

61.00

62.00

63.00

64.00

65.00

66.00

67 00

68.00

69 00

70.00

100.00 TOTAL

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

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

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/26/2023 3:03 pm Hospi ce CCN: 15-1564

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1. 00	CAP REL COSTS-BLDG & FIXT*	0	0	•	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	•	2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	-12, 095	405, 181		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	71, 366	1	5.00
6. 00	LAUNDRY & LINEN SERVICE*	0	0	•	6.00
7. 00	HOUSEKEEPI NG*	0	0	1	7.00
8. 00	DI ETARY*	0	0	1	8.00
9.00	NURSI NG ADMI NI STRATI ON*	0	0	1	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	200	•	10.00
11.00	MEDICAL RECORDS*	0	0	•	11.00
12.00	STAFF TRANSPORTATION*	0	0	•	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	1	13.00
14.00	PHARMACY*	0	101	•	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	•	15.00
16. 00 17. 00	OTHER GENERAL SERVICE*	U	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES DIRECT PATIENT CARE SERVICE COST CENTERS				17. 00
25. 00	INPATIENT CARE-CONTRACTED**	ol	0	I	25. 00
26. 00	PHYSICIAN SERVICES**	0	26, 494	1	26.00
27. 00	NURSE PRACTITIONER**		20, 494		27.00
28. 00	REGISTERED NURSE**		327, 269		28.00
29. 00	LPN/LVN**	0	327, 209	1	29.00
30.00	PHYSI CAL THERAPY**		0		30.00
31. 00	OCCUPATIONAL THERAPY**	0	0		31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY**	0	0	1	32.00
33. 00	MEDICAL SOCIAL SERVICES**		49, 340	•	33.00
34. 00	SPIRITUAL COUNSELING**		17, 540	1	34.00
35. 00	DI ETARY COUNSELI NG**		0	•	35.00
36. 00	COUNSELING - OTHER**	0	0		36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	28, 932	1	37.00
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	0	•	38.00
39. 00	PATI ENT TRANSPORTATI ON**	0	0	1	39.00
40. 00	I MAGI NG SERVI CES**	0	0	1	40.00
41.00	LABS & DI AGNOSTI CS**	o	0	•	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	o	0	•	42.00
42.50	DRUGS CHARGED TO PATIENTS**	o	0		42. 50
43.00	OUTPATIENT SERVICES**	o	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	o	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY) **	o	0		46.00
	NONREI MBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAI SI NG*	0	0	1	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	•	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	1	65. 00
66.00	RESI DENTI AL CARE*	0	0		66.00
67. 00	ADVERTI SI NG*	0	0	•	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0	•	68.00
69. 00	THRI FT STORE*	0	0	•	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	1	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	1	71.00
100.00	O TOTAL	-12, 095	908, 883		100.00

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

	El contal Contan	NDV COUNTY MEMO	DIAL HOCDITAL			. C. F OHC .	2552 40
	Financial Systems HE SIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	NRY COUNTY MEMO	Provider CO	N. 15 0020	In Lie Period:	w of Form CMS-2 Worksheet 0-2	
CARE	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E ROUTINE HOWE	Provider CC		From 01/01/2022		
ONICE			Hospi ce CCN	l: 15-1564	To 12/31/2022		
					Hospi ce I	5/26/2023 3:0	3 pm
		SALARI ES	OTHER	SUBTOTAL	RECLASSIFI -	SUBTOTAL	
		ONEMIN ES	OTHER	(col . 1 +	CATIONS	JOBIOTAL	
				col . 2)			
		1. 00	2.00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	I NPATI ENT CARE-CONTRACTED						25. 00
26. 00	PHYSI CI AN SERVI CES	26, 193	0	26, 19	3 0	26, 193	
27. 00	NURSE PRACTITIONER	0	0		0		27. 00
28. 00	REGI STERED NURSE	323, 549	0	323, 54	9 0	323, 549	28. 00
29. 00	LPN/LVN	0	0		0	0	29.00
30.00	PHYSI CAL THERAPY	0	0		0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0		0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	48, 779	0	48, 77	9 0	48, 779	
34.00	SPIRITUAL COUNSELING	0	0		0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0		0	0	35.00
36.00	COUNSELING - OTHER	00 (00	0	00.40	0	0	36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES	28, 603	0	28, 60	3 0	28, 603	37.00
38.00	DURABLE MEDI CAL EQUI PMENT/OXYGEN	0	U		0	0	
39. 00	PATIENT TRANSPORTATION	0	U		0	0	39.00
40.00	I MAGING SERVICES	0	U		0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	U		0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	U		0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICES	0	U		0	0	42.50
43.00		0	U		0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY		U		0	0	1
45. 00 46. 00	PALLIATIVE CHEMOTHERAPY		U		0		45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	l U	٩		u _l 0	0	46. 00

^{100.00} TOTAL * * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5	
			± col . 6)	
	DI DEGT. DATIENT, GADE, CEDIULGE, COCT. GENTEDO	6. 00	7.00	
05 00	DIRECT PATIENT CARE SERVICE COST CENTERS			05 00
25. 00	I NPATI ENT CARE-CONTRACTED		0, 400	25.00
26. 00	PHYSI CI AN SERVI CES	0	26, 193	26. 00
27. 00	NURSE PRACTITIONER	0	0	27.00
28. 00	REGI STERED NURSE	0	323, 549	28. 00
29. 00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31. 00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	48, 779	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	28, 603	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39. 00	PATI ENT TRANSPORTATION	0	0	39. 00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	427, 124	100.00

427, 124 100. 00

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

Health Financial Systems H ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI	CE INDATIENT	Provi der CC	N: 15_0030	Peri od:	u of Form CMS-2 Worksheet 0-3	
RESPITE CARE	CL INIAIILNI	Trovider co	N. 13-0030	From 01/01/2022	WOI KSHEET 0-3	
RESTITE OME		Hospi ce CCN	: 15-1564	To 12/31/2022	Date/Time Pre	
					5/26/2023 3:0	13 pm
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSIFI -	SUBTOTAL	
			(col. 1 +	CATIONS		
	1.00	2.00	col. 2) 3.00	4.00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS	1. 00	2.00	3.00	4. 00	5.00	
25. 00 INPATIENT CARE-CONTRACTED		٥			0	25. 00
26. 00 PHYSICIAN SERVICES	245	0	24	0	245	
27. 00 NURSE PRACTITIONER	245	0	22	15	245	27.00
28. 00 REGISTERED NURSE	3, 031	0	3, 03	0	3, 031	
29. 00 LPN/LVN	3,031	0	3, 03		3,031	
30. 00 PHYSI CAL THERAPY		0			0	30.00
31. 00 OCCUPATIONAL THERAPY		0			0	31.00
32. 00 SPEECH/LANGUAGE PATHOLOGY		0			0	32.00
33. 00 MEDICAL SOCIAL SERVICES	457	0	45	7 0	457	33.00
34. 00 SPIRITUAL COUNSELING	457	0	4.	,,	437	34.00
35. 00 DI ETARY COUNSELING		0			0	35.00
36. 00 COUNSELING - OTHER		0			0	36.00
37. 00 HOSPICE ALDE & HOMEMAKER SERVICES	268	0	26	. 0	268	1
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	200	0	20	0	200	38.00
39. 00 PATIENT TRANSPORTATION		0			0	39.00
40.00 IMAGING SERVICES		0			0	40.00
41. 00 LABS & DIAGNOSTICS		0			0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE		0			0	42.00
42.50 DRUGS CHARGED TO PATIENTS		0			0	42.50
43. 00 OUTPATIENT SERVICES		0			0	43. 00
44. 00 PALLIATIVE RADIATION THERAPY		0			0	44.00
45. 00 PALLIATIVE CHEMOTHERAPY		0		o o	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)		0			0	46.00
100. 00 TOTAL *	4, 001	o o	4, 00	0	•	100.00

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col . 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	245	26.00
27.00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	3, 031	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	457	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36. 00	COUNSELING - OTHER	0	0	36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES	0	268	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39. 00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41. 00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	4, 001	100.00

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

Health Financial Systems	ENRY COUNTY MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI	CE GENERAL	Provi der CC		Peri od:	Worksheet 0-4	
I NPATI ENT CARE		Hospi ce CCN		From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
					5/26/2023 3:0	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col . 2)			
DUDGOT DATIENT GADE GERMINE GOOT GENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS	T T	۵۱				05.00
25. 00 INPATIENT CARE-CONTRACTED		0	-	0	0	25.00
26. 00 PHYSI CI AN SERVI CES	56	0	5	0	56	
27. 00 NURSE PRACTITIONER	0	0		0	0	27.00
28. 00 REGI STERED NURSE 29. 00 LPN/LVN	689	0	68	0	689	
30. 00 PHYSI CAL THERAPY	0	O O		0	0	29. 00 30. 00
31. 00 OCCUPATIONAL THERAPY	0	0		0	0	31.00
32. 00 SPEECH/LANGUAGE PATHOLOGY		0			0	32.00
33. 00 MEDI CAL SOCI AL SERVI CES	104	0	10	0	104	
34. 00 SPIRI TUAL COUNSELING	104	0	10	0	0	34.00
35. 00 DI ETARY COUNSELING		0			0	35.00
36. 00 COUNSELING - OTHER		0		0 0	0	36.00
37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES	61	0	f	0	61	37.00
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN		0		0	0	38.00
39. 00 PATIENT TRANSPORTATION		0		0 0	0	39.00
40.00 IMAGING SERVICES	l ol	0		0 0	Ō	40.00
41. 00 LABS & DIAGNOSTICS	o	0		0 0	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	o	0		0 0	0	42.00
42.50 DRUGS CHARGED TO PATIENTS	o	0		0 0	0	42.50
43. 00 OUTPATIENT SERVICES	o	0		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY		0		0	0	44.00
45. 00 PALLIATIVE CHEMOTHERAPY	0	o		0	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0	0	46. 00
100. 00 TOTAL *	910	0	91	0 0	910	100.00

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col . 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSI CI AN SERVI CES	0	56	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	689	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	104	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	61	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39. 00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41. 00	LABS & DI AGNOSTI CS	0	0	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45. 00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	910	100.00

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

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET Provider CCN: 15-0030 Hospice CCN: 15-1040 H	Heal th	Financial Systems HENRY COUNTY MEMO	DRIAL HOSPITAL	=	In Lie	u of Form CMS-2	2552-10
Descriptions	COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der C				
Descriptions	EXPENS	ES FOR ALLOCATION	Hospi ce CCN: 15-1564		From 01/01/2022 To 12/31/2022		
Descriptions					Hospi ce I	072072020 0.0	о рііі
EXPENSES (See EXPENSES FROM OF COLS. 1 +		Descriptions		HOSPI CE		TOTAL	
Instructions		'		DI RECT	SERVI CE	EXPENSES (sum	
CSEC Instructions CSEC Instructions CSEC Instructions CSEC CSEC CENTERS CAP REL COSTS-BLDG & FLXT O				EXPENSES (se	e EXPENSES FROM	of cols. 1 +	
CEMERAL SERVICE COST CENTERS				instructions) WKST B PART I	2)	
CAP REL COSTS-BLDG & FIXT 0 0 0 0 0 0 0 0 0					(see	·	
GENERAL SERVICE COST CENTERS					instructions)		
1.00				1. 00	2.00	3. 00	
2. 00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
3.00					0		
A 00 ADMINI STRATIVE & GENERAL A 05, 181 209, 773 614, 954 4, 00 C 0					-		
5.00 PLANT OPERATION & MAINTENANCE 71,366 69,325 140,691 5.00 6.00 LAUNDRY & LINEN SERVICE 0 0 0 0 0 0 6.00 8.00 DIETARY 0 0 0 14,317 14,317 14,317 71,317 7							
6.00 LAUNDRY & LINEN SERVICE						614, 954	
NOTE	5.00	PLANT OPERATION & MAINTENANCE		71, 36	69, 325	140, 691	5.00
8. 00 DI ETARY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6.00	LAUNDRY & LINEN SERVICE			0		
9. 00 NURSING ADMINISTRATION 0 0 9. 00 10. 00 ROUTI NE MEDI CAL SUPPLIES 200 1, 041 1, 241 10. 00 11. 00 MEDI CAL RECORDS 0 1, 887 11. 00 0 12. 00 12. 00 STAFF TRANSPORTATI ON 0 0 12. 00 12. 00 13. 00 VOLUNTEER SERVI CE COORDI NATI ON 0 0 13. 00 14. 00 PHARMACY 101 0 101 14. 00 15. 00 PHYSI CI AN ADMINI STRATI VE SERVI CES 0 0 0 15. 00 16. 00 OTHER GENERAL SERVI CE 0 0 0 16. 00 17. 00 PATI ENTI-YRESI DENTI AL CARE SERVI CES 0 0 0 16. 00 17. 00 HOSPI CE CONTI NUOUS HOME CARE 0 0 0 50. 00 51. 00 HOSPI CE ROUTI NE HOME CARE 427, 124 427, 124 51. 00 53. 00 HOSPI CE GENERAL I INPATI ENT RESPITE CARE 4, 001 910 53. 00 60		HOUSEKEEPI NG			0 14, 317	14, 317	7.00
10. 00 ROUTI NE MEDI CAL SUPPLIES 200 1, 041 1, 241 10. 00 11. 00 12. 00 1, 887 1, 887 11. 00 12. 00 1, 887 11. 00 12. 00 1, 887 11. 00 12. 00 13. 00 10. 00 10. 00 13. 00 13. 00 14. 00 14. 00 15. 00 10. 10. 10. 10. 10. 10. 10. 10. 10. 10.	8.00	DI ETARY			0	0	8.00
11.00 MEDI CAL RECORDS 0 1,887 1,887 11.00 12.00 12.00 13.00	9.00				0	0	9. 00
12.00 STAFF TRANSPORTATION 0 0 12.00 13.00 VOLUNTEER SERVICE COORDINATION 0 0 13.00 14.00 PHARMACY 101 0 101 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 0 15.00 16.00 OTHER GENERAL SERVICE 0 0 0 0 17.00 17.00 LEVEL OF CARE 0 0 0 0 17.00 HOSPICE CONTINUOUS HOME CARE 427, 124 427, 124 51.00 15.00 HOSPICE ROUTINE HOME CARE 427, 124 427, 124 51.00 17.00 STAFF TRANSPORTATION 0 0 0 10.10 10.10 10.10 10.10 10.10 10.10 10.	10.00			20	1, 041	1, 241	10.00
13. 00 VOLUNTEER SERVI CE COORDI NATI ON 0 13. 00 14. 00 PHARMACY 101 0 101 14. 00 15. 00 PHARMACY 101 0 101 14. 00 15. 00 OTHER GENERAL SERVI CE 0 0 0 0 16. 00 OTHER GENERAL SERVI CE 0 0 0 17. 00 PATI ENT/RESI DENTI AL CARE SERVI CES 0 0 0 17. 00 DEVEL OF CARE 0 0 0 17. 00 HOSPI CE CONTI INUOUS HOME CARE 0 0 50. 00 17. 00 HOSPI CE INPATI ENT RESPI TE CARE 4,001 4,001 52. 00 18. 00 HOSPI CE GENERAL INPATI ENT CARE 910 910 53. 00 19. 00 NONREI MBURSABLE COST CENTERS 910 910 910 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0. 00 19. 00 OULUNTEER PROGRAM 0 0 0 0 0 19. 00 OULUNTEER PROGRAM 0 0 0 0 0 19. 00 OULUNTEER PROGRAM 0 0 0 0 19. 00					0 1, 887		
14. 00 PHARMACY 101 0 101 14. 00 15. 00 15. 00 15. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 17. 00 1	12.00	STAFF TRANSPORTATION			0	l	12.00
15. 00					0		
16. 00 OTHER GENERAL SERVICE 0 0 0 0 16. 00 17. 00 EVEL OF CARE				10			
17. 00					0	l .	1
LEVEL OF CARE					٦		
50. 00 HOSPI CE CONTINUOUS HOME CARE 0 0 0 50. 00 51. 00 HOSPI CE ROUTI NE HOME CARE 427, 124 427, 124 52. 00 HOSPI CE INPATI ENT RESPITE CARE 4, 001 4, 001 52. 00 53. 00 HOSPI CE GENERAL INPATI ENT CARE 910 910 53. 00 NONREI MBURSABLE COST CENTERS	17. 00				0	0	17. 00
51.00 HOSPI CE ROUTI NE HOME CARE 427, 124 427, 124 51.00 52.00 HOSPI CE INPATI ENT RESPITE CARE 4,001 4,001 52.00 53.00 HOSPI CE GENERAL INPATI ENT CARE 910 910 53.00 NONREI MBURSABLE COST CENTERS 0 0 60.00 60.00 BEREAVEMENT PROGRAM 0 0 61.00 61.00 VOLUNTEER PROGRAM 0 0 61.00 62.00 FUNDRAI SI NG 0 0 62.00 63.00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 63.00 64.00 PALLI ATI VE CARE PROGRAM 0 0 64.00 65.00 OTHER PHYSI CI AN SERVI CES 0 0 65.00 66.00 RESI DENTI AL CARE 0 0 66.00						г	
10 10 10 10 10 10 10 10					<u> </u>		
53. 00 HOSPICE GENERAL INPATIENT CARE 910 910 53. 00 NONREI MBURSABLE COST CENTERS 0 0 60. 00 60. 00 BEREAVEMENT PROGRAM 0 0 61. 00 62. 00 FUNDRAI SI NG 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES 0 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 66. 00							
NONREI MBURSABLE COST CENTERS 0							
60. 00 BEREAVEMENT PROGRAM 0 0 60. 00 61. 00 VOLUNTEER PROGRAM 0 0 61. 00 62. 00 FUNDRAI SI NG 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES 0 0 0 65. 00 66. 00 RESI DENTI AL CARE	53.00			91	0	910	53.00
61. 00 VOLUNTEER PROGRAM 62. 00 FUNDRAI SI NG 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 0 0 61. 00 6 2. 00 0 62. 00 0 63. 00 0 64. 00 0 64. 00 0 65. 00 0 66. 00							
62. 00 FUNDRAISING 0 0 62. 00 63. 00 HOSPI CE/PALLIATI VE MEDI CI NE FELLOWS 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM 0 0 65. 00 65. 00 OTHER PHYSI CI AN SERVI CES 0 0 66. 00 66. 00 RESI DENTI AL CARE 0 0 66. 00					-		
63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM 0 0 65. 00 65. 00 OTHER PHYSI CI AN SERVI CES 0 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 66. 00					0		
64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 0 0 64. 00 65. 00 66. 00					U		
65. 00 OTHER PHYSI CI AN SERVI CES 0 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 66. 00					U		1
66. 00 RESI DENTI AL CARE 0 66. 00					U		
					U		
					<u> </u>		

67.00

68. 00 69. 00

0 0 0 70.00

0 71.00

0 99.00 1, 386, 225 100.00

477, 342

908, 883

67. 00 ADVERTISING

68. 00 TELEHEALTH/TELEMONITORING
69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD
71. 00 OTHER NONREIMBURSABLE (SPECIFY)
99. 00 NEGATIVE COST CENTER
100. 00 TOTAL

	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI	ERVICE COSTS	Provi der C	CN: 15-0030	Peri od: From 01/01/2022 To 12/31/2022		pared:
					Hospi ce I		
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBL	E EMPLOYEE	SUBTOTAL	
		EXPENSES	& FIX	EQUI P	BENEFITS		
					DEPARTMENT		
		0	1.00	2. 00	3. 00	3A	
	GENERAL SERVICE COST CENTERS	T		,			
1.00	CAP REL COSTS-BLDG & FLXT	0	0	1			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	180, 999			0 180, 999		3.00
4.00	ADMINISTRATIVE & GENERAL	614, 954	0	1	0	614, 954	
5.00	PLANT OPERATION & MAINTENANCE	140, 691	0	1	0	140, 691	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0	0	6.00
7.00	HOUSEKEEPI NG	14, 317	0		0	14, 317	7.00
8.00	DI ETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	1, 241	0		0	1, 241	10.00
11.00	MEDI CAL RECORDS	1, 887	0	1	0	1, 887	11.00
12.00	STAFF TRANSPORTATION	0	0	1	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0)	0 0	0	13.00
14.00	PHARMACY	101	l 0)	0 0	101	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	l 0)	0 0	0	15.00
16.00	OTHER GENERAL SERVICE	0	l o		0 0	0	16.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES		0	,	0	0	17.00
	LEVEL OF CARE	<u>'</u>	<u>'</u>				1
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	427, 124			178, 942	606, 066	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	4, 001	l o)	0 1, 676	5, 677	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	910)	0 381	1, 291	53.00
	NONREI MBURSABLE COST CENTERS	1		'		·	Ī
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	1	0 0	0	61.00
62.00	FUNDRAI SI NG	0	l o)	0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00		0			0	0	65.00
66. 00		0			o o	0	66.00
67. 00	ADVERTI SI NG	0	1 0	,	ol ol	0	67.00
	TELEHEALTH/TELEMONI TORI NG	0	1 0	,	ol ol	0	68.00
	THDIET STORE		1			0	1

0 69.00

1, 386, 225 100. 00

0 0 0 70.00

71. 00 99. 00

69.00 THRIFT STORE

70.00 NURSING FACILITY ROOM & BOARD

71.00 OTHER NONREI MBURSABLE (SPECIFY)
99.00 NEGATI VE COST CENTER
100.00 TOTAL

Health FinancialSystemsHENRY COUNTY MCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERALSERVICE COSTS Provi der CCN: 15-0030 Hospi ce CCN: 15-1564

						3/20/2023 3.0	is pili
					Hospi ce I		
	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	OPERATION &	LINEN SERVICE			
			MAI NTENANCE				
		4. 00	5. 00	6. 00	7.00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT					I	1.00
2.00	CAP REL COSTS-MVBLE EQUIP					I	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					I	3.00
4.00	ADMINISTRATIVE & GENERAL	614, 954				I	4.00
5.00	PLANT OPERATION & MAINTENANCE	112, 176	252, 867			I	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0		I	6.00
7.00	HOUSEKEEPI NG	11, 415	0		25, 732	I	7. 00
8.00	DI ETARY	0	0		o	0	8.00
9.00	NURSING ADMINISTRATION	0	0		o	I	9.00
10.00	ROUTINE MEDICAL SUPPLIES	989	0		o	I	10.00
11.00	MEDI CAL RECORDS	1, 505	252, 867		o	I	11.00
12.00	STAFF TRANSPORTATION	0	0		o	I	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		ol	I	13.00
14.00	PHARMACY	81	0		o	I	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		ol	I	15.00
16.00	OTHER GENERAL SERVICE	0	0		o	I	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		o	I	17.00
	LEVEL OF CARE						1
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	483, 233				I	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	4, 526	0	0	20, 968	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1, 029	0	0	4, 764	0	53.00
	NONREI MBURSABLE COST CENTERS						1
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0	I	61.00
62.00	FUNDRAI SI NG	0	0		0	I	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	I	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0	I	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0	I	65.00
66.00	RESI DENTI AL CARE	0	0	0	0	0	
67.00	ADVERTI SI NG	0	0		0	I	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0	I	68.00
69.00	THRI FT STORE	0	0		0	I	69. 00
70.00	NURSING FACILITY ROOM & BOARD					I	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	
99. 00	NEGATI VE COST CENTER	0	0	0		0	
100.00	TOTAL	614, 954	252, 867	0	25, 732	0	100.00

Heal th	Financial Systems	HENRY COUNTY MEMOR	RIAL HOSPITAL	=	In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der C	CN: 15-0030	Peri od:	Worksheet 0-6	<u> </u>
					From 01/01/2022		
			Hospi ce CC	N: 15-1564	To 12/31/2022		
						5/26/2023 3:0	03 pm
					Hospi ce I		
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI O	MEDI CAL	RECORDS	TRANSPORTATI 0	SERVI CE	
		N	SUPPLI ES		N	COORDI NATI ON	
		9. 00	10.00	11. 00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG	1					7.00
							1
8. 00	DI ETARY						8.00
9. 00	NURSI NG ADMI NI STRATI ON	0					9.00
10. 00	ROUTINE MEDICAL SUPPLIES	O	2, 230	1			10.00
11. 00	MEDI CAL RECORDS	0		256, 2	59		11. 00
12. 00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	O			0	0	15.00
16.00	OTHER GENERAL SERVICE	o			0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE	<u>'</u>		•			
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE		2, 204	1		l	1
52. 00	HOSPICE INPATIENT RESPITE CARE		21	1			
53. 00	HOSPICE GENERAL INPATIENT CARE		5		39 0		
55.00		١		1 3	37 0	U	33.00
40.00	NONREI MBURSABLE COST CENTERS	0		I		0	40.00
60.00	BEREAVEMENT PROGRAM				0		
61.00	VOLUNTEER PROGRAM	O O			0	1	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o o			0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0			0	0	
65. 00	OTHER PHYSICIAN SERVICES				0	0	65.00
66.00	RESI DENTI AL CARE	0			0	0	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	o			0	0	68.00
69.00	THRI FT STORE	ol			0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD			[Ī	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)				n	0	
99. 00	NEGATI VE COST CENTER		0		0 0	0	
	TOTAL		2, 230	256, 2	-	1	100.00
100.00	/ IVIAL	١	2, 230	1 230, 2	3/1	, ,	1100.00

Health FinancialSystemsHENRY COUNTY MCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERALSERVICE COSTS Provi der CCN: 15-0030 | Peri od: From 01/01/2022 | Part I |
Hospi ce CCN: 15-1564 | To 12/31/2022 | Date/Time Prepared: 5/26/2023 3:03 pm

						5/26/2023 3:0	13 pm
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
	·		ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
			E SERVICES		CARE SERVICES		
		14. 00	15. 00	16.00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS	1 11 00	10.00	10.00	171.00	10.00	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7.00
8. 00	DI ETARY						8.00
9. 00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11.00
12. 00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	182					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	C				15.00
16.00	OTHER GENERAL SERVICE	0					16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						1
50.00	HOSPICE CONTINUOUS HOME CARE	0	C) (0	50.00
51.00	HOSPICE ROUTINE HOME CARE	180	l c) (1, 345, 030	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2	l c		0	33, 567	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0			0	7, 628	53.00
	NONREI MBURSABLE COST CENTERS			'	<u>'</u>		1
60.00	BEREAVEMENT PROGRAM	0		()	0	60.00
61.00	VOLUNTEER PROGRAM	0				0	61.00
62.00	FUNDRAI SI NG	0				0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	63.00
64.00	PALLIATIVE CARE PROGRAM	0				0	64.00
65.00	OTHER PHYSICIAN SERVICES	0				O	65.00
66. 00	RESI DENTI AL CARE	0	l c		0	0	66.00
67. 00	ADVERTI SI NG	0				0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG					0	68.00
69. 00						0	69.00
70. 00	NURSING FACILITY ROOM & BOARD				1	0	70.00
	l control of the cont		C	,		0	1
	OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER				-		1
	l e e e e e e e e e e e e e e e e e e e	100				_	
100.00	TOTAL	182	[C) (0	1, 386, 225	1100.00

Health Financial Systems	HENRY COUNTY MEM	IORI AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provi der CO		Peri od:	Worksheet 0-6	
STATI STI CAL BASI S				From 01/01/2022		
		Hospi ce CCi	N: 15-1564	To 12/31/2022	5/26/2023 3:0	
					3/20/2023 3.0	3 piii
				Hospi ce I		
Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI O	ADMI NI STRATI V	
	& FIX	EQUI P	BENEFI TS	N	E & GENERAL	
	(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
		\/ALUE\	(CDOCC		COCTC	

				Hospi ce I		
Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI O	ADMI NI STRATI V	
	& FIX	EQUI P	BENEFITS	N	E & GENERAL	
	(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
		VALUE)	(GROSS		COSTS)	
		ĺ	SALARI ES)		Í	
	1. 00	2. 00	3.00	4A	4. 00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT	0					1.00
2.00 CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT	0	l o	167, 512			3.00
4. OO ADMINISTRATIVE & GENERAL	0	0	0		771, 271	4.00
5.00 PLANT OPERATION & MAINTENANCE	0	0	0	0	140, 691	5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7. 00 HOUSEKEEPI NG	0	0	١	0	14, 317	7.00
8. 00 DI ETARY	0	١	١	0	0	8.00
9. 00 NURSING ADMINISTRATION		0		0	0	9.00
10. 00 ROUTINE MEDICAL SUPPLIES				0	1, 241	
11. 00 MEDI CAL RECORDS				0	1, 241	•
12. 00 STAFF TRANSPORTATION	0	0		0	1, 887	1
13. 00 VOLUNTEER SERVICE COORDINATION	0	0		0	0	1
	0	0		0	_	•
14. 00 PHARMACY	0	0	0	0	101	•
15. 00 PHYSI CI AN ADMINISTRATI VE SERVI CES	0	0	0	0	0	
16. 00 OTHER GENERAL SERVI CE	0	ľ	0	0	0	16.00
17. 00 PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
LEVEL OF CARE		ı	1		0	
50. 00 HOSPI CE CONTINUOUS HOME CARE			0	_	0	
51.00 HOSPICE ROUTINE HOME CARE			165, 608		606, 066	
52.00 HOSPICE INPATIENT RESPITE CARE	0		.,	0	5, 677	
53. 00 HOSPICE GENERAL INPATIENT CARE	0	0	353	0	1, 291	53.00
NONREI MBURSABLE COST CENTERS						
60. 00 BEREAVEMENT PROGRAM	0	1	0	_	0	
61. 00 VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62. 00 FUNDRAI SI NG	0	0	0	0	0	62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	
64.00 PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65. 00 OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66. 00 RESI DENTI AL CARE	0	0	0	0	0	66. 00
67. 00 ADVERTI SI NG	0	0	0	0	0	67.00
68. 00 TELEHEALTH/TELEMONI TORI NG	0	0	0	0	0	
69. 00 THRI FT STORE	0	0	0	0	0	69. 00
70.00 NURSING FACILITY ROOM & BOARD				0		70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00 NEGATIVE COST CENTER						99. 00
100.00 COST TO BE ALLOCATED (per Wkst. 0-6, P	art I) 0	0	180, 999		614, 954	
101.00 UNIT COST MULTIPLIER	0. 000000	0. 000000	1. 080514		0. 797325	101.00
•	·	•				

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPIC STATISTICAL BASIS		-0030 Period: Worksheet 0-6 From 01/01/2022 Part II 5-1564 To 12/31/2022 Date/Time Prepared:
		F /2/ /2022 2: 02 pm

;	SIAIIS	TICAL BASIS		Hospi ce CCI		To 12/31/2022		
_						Hospi ce I	0, 20, 2020 0.0	<u> </u>
		Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		·	OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMINISTRATIO	
			MAI NTENANCE	(IN-FACILITY		DAYS)	N	
			(SQUARE FEET)	DAYS)			(DI RECT NURS.	
							HRS.)	
			5. 00	6. 00	7. 00	8. 00	9. 00	
		GENERAL SERVICE COST CENTERS						
	1. 00	CAP REL COSTS-BLDG & FLXT						1.00
	2. 00	CAP REL COSTS-MVBLE EQUIP						2.00
	3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4	4. 00	ADMINISTRATIVE & GENERAL						4.00
í	5. 00	PLANT OPERATION & MAINTENANCE	2, 290					5. 00
(6. 00	LAUNDRY & LINEN SERVICE	0	0	1			6. 00
-	7. 00	HOUSEKEEPI NG	0		2, 29	0		7.00
8	3. 00	DI ETARY	0			0		8. 00
(9. 00	NURSI NG ADMI NI STRATI ON	0			0	0	9. 00
•	10. 00	ROUTINE MEDICAL SUPPLIES	0			0	0	10.00
•	11. 00	MEDI CAL RECORDS	2, 290			0	0	11.00
•	12.00	STAFF TRANSPORTATION	0			0	0	12.00
•	13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
•	14.00	PHARMACY	0			0	0	14.00
•	15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
•	16. 00	OTHER GENERAL SERVICE	0			0	0	16.00
•	17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0			0		17. 00
		LEVEL OF CARE						
į	50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
į	51. 00	HOSPICE ROUTINE HOME CARE					0	51.00
į	52. 00	HOSPICE INPATIENT RESPITE CARE	0	0	1, 86	6 0	0	52.00
į	53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	42	4 0	0	53.00
		NONREI MBURSABLE COST CENTERS						
(60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
(61. 00	VOLUNTEER PROGRAM	0			0	0	61.00
(62. 00	FUNDRAI SI NG	0			0	0	62.00
(63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
(64. 00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
(65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
(66. 00	RESI DENTI AL CARE	0	0		0	0	66.00
(67. 00	ADVERTI SI NG	0			0	0	67.00
	68. 00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
	69. 00	THRI FT STORE	0			0	0	69. 00
-	70. 00	NURSING FACILITY ROOM & BOARD						70. 00
	71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	71.00
	99. 00	NEGATI VE COST CENTER						99. 00
		COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	252, 867	0	25, 73			100.00
•	101. 00	UNIT COST MULTIPLIER	110. 422271	0. 000000	11. 23668	0.000000	0.000000	101. 00

	NLLOCATION - HOSPITAL-BASED HOSPICE GENERAL S STICAL BASIS	ERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2022 To 12/31/2022	Worksheet 0-6 Part II Date/Time Pre 5/26/2023 3:0	pared:
-					Hospi ce I		<u> </u>
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDI CAL RECORDS (PATI ENT DAYS)	STAFF TRANSPORTATION N (MI LEAGE)	VOLUNTEER SERVI CE COORDI NATI ON (HOURS OF SERVI CE)	PHARMACY (CHARGES)	
		10. 00	11. 00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
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	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES	4, 751	4, 751		0 0 0 0 0 0	4, 751 0	1
16. 00 17. 00	OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES			'	0 0	0	16. 00 17. 00
17.00	LEVEL OF CARE						17.00
50. 00 51. 00 52. 00 53. 00	HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	0 4, 697 44 10	0 4, 697 44 10		0 0 0 0 0 0 0 0	0 4, 697 44 10	51. 00 52. 00
60.00	BEREAVEMENT PROGRAM				0 0	0	60.00
61.00	VOLUNTEER PROGRAM			l .	0 0	0	00.00
62.00	FUNDRAI SI NG				0	0	02.00
63. 00 64. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM			1	0 0	0	
65. 00	OTHER PHYSICIAN SERVICES			1	0 0	0	
66. 00	RESI DENTI AL CARE			1	0 0	0	1
67. 00	ADVERTI SI NG			•	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			1	0 0	0	
69.00	THRIFT STORE				0	0	69.00

2, 230

0. 469375

256, 259

53. 937908

69. 00 70. 00

71.00

99.00

182 100. 00 0. 038308 101. 00

0

0.000000

0.000000

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

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

99.00 NEGATIVE COST CENTER

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STATISTICAL BASIS		30

						5/26/2023 3:03 pm
				_	Hospi ce I	
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/		
		ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
		E SERVICES	(SPECI FY	CARE SERVICES		
		(PATI ENT	BASIS)	(IN-FACILITY		
		DAYS)	,	DAYS)		
		15. 00	16. 00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FLXT					1.00
2. 00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4. 00	ADMI NI STRATI VE & GENERAL					4.00
5. 00	PLANT OPERATION & MAINTENANCE					5.00
6. 00	LAUNDRY & LINEN SERVICE					6.00
7. 00						7.00
	HOUSEKEEPI NG					
8. 00	DI ETARY					8.00
9. 00	NURSI NG ADMI NI STRATI ON					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11. 00	MEDI CAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15. 00
	OTHER GENERAL SERVICE		0			16.00
	PATIENT/RESIDENTIAL CARE SERVICES			l c		17.00
	LEVEL OF CARE		<u>'</u>	'	"	
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
	HOSPICE ROUTINE HOME CARE	0	0	l		51.00
	HOSPICE INPATIENT RESPITE CARE		١			52.00
53.00	HOSPICE GENERAL INPATIENT CARE		0			53.00
33.00	NONREI MBURSABLE COST CENTERS				′	33.00
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
			0			
62.00	FUNDRAL SI NG		0			62.00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
	PALLIATIVE CARE PROGRAM		0			64.00
	OTHER PHYSICIAN SERVICES		0			65. 00
66. 00	RESI DENTI AL CARE	0	0	C)	66. 00
67.00	ADVERTI SI NG		0			67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0			68.00
69.00	THRI FT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	C		71.00
	NEGATI VE COST CENTER					99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	ol o	0	1 0		100.00
	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 000000		101.00
101.00	UNIT COST MULTIPLIER	0.00000	J 0. 000000	J 0. 00000C	' I	1101.0

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE LEVEL OF CARE	SHARED SERVICE COSTS BY	Provider CCN: 15-0030 Hospice CCN: 15-1564	From 01/01/2022	
				5/26/2023 3:03 pm

LEVEL	UF CARE		Hospi ce CCI		To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
					Hospi ce I		
			·	Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	HCHC	HRHC	HI RC	
		0	1. 00	2. 00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66.00			0	0	1. 00
2.00	OCCUPATIONAL THERAPY	67. 00			0	0	2. 00
3. 00	SPEECH PATHOLOGY	68. 00		•	0	0	3.00
4. 00	DRUGS CHARGED TO PATIENTS	73. 00			0	0	
5. 00	DURABLE MEDI CAL EQUI P-RENTED	96. 00			_	_	5.00
6.00	LABORATORY	60.00			0	0	6.00
6. 01	BLOOD LABORATORY	60. 01	0. 000000		0	0	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00			0	0	,
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	l .				8.00
9.00	RADI OLOGY-THERAPEUTI C	55.00					9.00
10. 00 11. 00	CARDIAC REHAB Totals (sum of lines 1-11)	76. 00	0. 533046	1	0	0	10. 00 11. 00
11.00	Total's (Suil Of Titles 1-11)	Charges by		Sharod Sorvi	ce Costs by LOC		11.00
		LOC (from Provi der Records)		Shareu Servic	ce costs by Loc		
	Cost Center Descriptions	HGI P	HCHC (col. 1	HRHC (col. 1	HIRC (col. 1	HGIP (col. 1	
	·		x col . 2)	x col . 3)	x col. 4)	x col. 5)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	ANCILLARY SERVICE COST CENTERS				_		
1.00	PHYSI CAL THERAPY	0	1		0	0	
2.00	OCCUPATI ONAL THERAPY	0	0		0	0	2.00
3. 00	SPEECH PATHOLOGY	0	0		0	0	
4. 00	DRUGS CHARGED TO PATIENTS	0	0	1	0	0	
5.00	DURABLE MEDI CAL EQUI P-RENTED						5.00
6.00	LABORATORY	0	0		0	0	
6. 01	BLOOD LABORATORY	0	0		0	0	
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0	0	,
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADI OLOGY-THERAPEUTI C	0	_]		_	9.00
10.00	CARDIAC REHAB Totals (sum of lines 1-11)	0	0		0 0	0	
11.00	Tiorars (sull of filles 1-11)	I	l 0	1	ار ا	, 0	1 11.00

AL	in Lieu	u of Form CMS-2552-10
CCN: 15-0030	Peri od:	Worksheet 0-8
	From 01/01/2022	
	CCN: 15-0030	CCN: 15-0030 Peri od: From 01/01/2022

		Hospice CCN	I: 15-1564 I	0 12/31/2022	5/26/2023 3:0	
				Hospi ce I	0, 20, 2020 0.0	<u>o p</u>
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1. 00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7 line 11)	, col . 6,			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	10)	0	0		4.00
5.00	Program cost (line 3 times line 4)		0	0		5.00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	, col. 7,			1, 345, 030	6.00
	line 11)					
7. 00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				4, 697	7.00
8. 00	Total average cost per diem (line 6 divided by line 7)				286. 36	8. 00
9. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	e 11)	4, 521			9. 00
10.00	Program cost (line 8 times line 9)		1, 294, 634	2, 005		10.00
	HOSPICE INPATIENT RESPITE CARE					
11. 00		, col. 8,			33, 567	11. 00
	line 11)					
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)					12.00
13. 00	Total average cost per diem (line 11 divided by line 12)				762. 89	
	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	e 12)	38			14.00
15.00	Program cost (line 13 times line 14)		28, 990	0		15. 00
4, 00	HOSPICE GENERAL INPATIENT CARE				7 (00	
16. 00		, col. 9,			7, 628	16. 00
17.00	line 11)				10	17.00
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)					17.00
18.00		- 12)	2	,	762. 80	19.00
	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	e 13)	2. 288	4 577		
20.00	Program cost (line 18 times line 19) TOTAL HOSPICE CARE		2, 288	4, 577		20.00
21 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)	T			1, 386, 225	21.00
	Total unduplicated days (Wkst. S-9, col. 4, line 14)	-			1, 386, 225 4, 751	1
	Average cost per diem (line 21 divided by line 22)				4, 751 291. 78	1
Z3. UU	[Average Cost per drem (Time 21 drvided by Time 22)				291. /8	∠3.UU

Hool th	Financial Systems HENRY COUNTY MEMOR	I AL HOSDITAL	In Lie	u of Form CMS-2	DEE2 10
	Financial Systems HENRY COUNTY MEMOR ATION OF CAPITAL PAYMENT	Provider CCN: 15-0030	Peri od:	Worksheet L	2552-10
CALCUL	ATTON OF CAPITAL PAYMENT	Provider CCN: 15-0030	From 01/01/2022		
			To 12/31/2022		pared:
			12,01,2022	5/26/2023 3:0	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			407, 375	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			1, 866	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2.01
3. 00	Total inpatient days divided by number of days in the cost re	enorting period (see ins	tructions)	24. 41	3.00
4. 00	Number of interns & residents (see instructions)	eportring period (see riis	tructrons)	0.00	4.00
5. 00	Indirect medical education percentage (see instructions)			0.00	5.00
6. 00	Indirect medical education percentage (see instructions)	o sum of lines 1 and 1 O	1 columns 1 and	0.00	6.00
0.00	1.01) (see instructions)	e sum of filles I and 1.0	i, corumns i and	U	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A	nationt days (Warkshoot	E part Alina	0.00	7. 00
7.00	30) (see instructions)	patrent days (worksheet	E, part A fine	0.00	7.00
8. 00	Percentage of Medicaid patient days to total days (see instru	usti ons)		0.00	8. 00
9. 00		uctions)			9.00
	Sum of lines 7 and 8	. `		0.00	
10.00	Allowable disproportionate share percentage (see instructions	S)		0.00	
11.00	Disproportionate share adjustment (see instructions)			0	11.00
12. 00	Total prospective capital payments (see instructions)			409, 241	12.00
				4 00	
	PART II - PAYMENT UNDER REASONABLE COST			1. 00	
1. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			1.00	1.00
1. 00 2. 00	Program inpatient routine capital cost (see instructions)				1.00
2.00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions)			0	2.00
	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2)			0	2. 00 3. 00
2. 00 3. 00 4. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions)			0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2)			0 0 0 0	2. 00 3. 00
2. 00 3. 00 4. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions)			0 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions)			0 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS	ces (see instructions)		0 0 0 0 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)	ces (see instructions)		0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2)	ces (see instructions)		0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstant Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			1.00 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstant Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions)	nstructions)	x line 6)	1.00 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary	nstructions)	x line 6)	1.00 0 0 0 0 0 0 0 0 0.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	nstructions) y circumstances (line 2	x line 6)	1.00 0 0 0 0 0 0 0 0 0.00 0 0.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 8. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applied)	nstructions) y circumstances (line 2 : icable)	ŕ	1.00 0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to describe the comparison of capital minimum payment level to describe the comparison of capital minimum payment level to describe the comparison of capital minimum payment level to describe the comparison of capital minimum payment level to describe the comparison of capital minimum payment level to describe the comparison of capital minimum payment level to describe the comparison of capital minimum payment level to describe the comparison of capital minimum payment level to describe the comparison of capital minimum payment level to describe the comparison of capital minimum payment level to describe the comparison of capital minimum payment level to describe the capital cost (line 1 plus line 2)	nstructions) y circumstances (line 2 icable) capital payments (line 8	less line 9)	0 0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14)	nstructions) y circumstances (line 2 icable) capital payments (line 8 capital payment (from pr	less line 9) ior year	0 0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as application of capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payments of capital minimum payment level to capital minimum p	nstructions) y circumstances (line 2 icable) capital payments (line 8 capital payment (from pr	less line 9) ior year ne 11)	0 0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurent year comparison of capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter	nstructions) y circumstances (line 2 icable) capital payments (line 8 capital payment (from pr ayments (line 10 plus lir the amount on this line	less line 9) ior year ne 11) e)	0 0 0 0 0 0 0 0 0 0.00 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level over of Carryover of accumulated capital minimum payment level to capital payments (promatory comparison of capital minimum payment level over of Carryover of accumulated capital minimum payment level to capital payment seem of capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Carryover of acc	nstructions) y circumstances (line 2 icable) capital payments (line 8 capital payment (from pr ayments (line 10 plus lir the amount on this line	less line 9) ior year ne 11) e)	0 0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over of (if line 12 is negative, enter the amount on this line)	nstructions) y circumstances (line 2 icable) capital payments (line 8 capital payment (from pr ayments (line 10 plus li r the amount on this lin capital payment for the	less line 9) ior year ne 11) e)	0 0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level over of accumulated capital minimum payment level over of current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over of (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see instructions)	nstructions) y circumstances (line 2 icable) capital payments (line 8 capital payment (from pr ayments (line 10 plus li r the amount on this lincapital payment for the	less line 9) ior year ne 11) e)	0 0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level over of Carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over of (if line 12 is negative, enter the amount on this line)	nstructions) y circumstances (line 2 icable) capital payments (line 8 capital payment (from pr ayments (line 10 plus li r the amount on this lincapital payment for the	less line 9) ior year ne 11) e)	0 0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00

ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-0030	Peri od:	Worksheet M-1	
			Component	CCN: 15-8520	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 3:0	pared:
					RHC I	Cost	<u> </u>
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1. 00	Physi ci an	1, 909, 682	26, 751	1, 936, 43		,	
2.00	Physician Assistant	0	C		0	0	2.00
3. 00	Nurse Practitioner	723, 797	C	723, 79	-137, 608		
4. 00	Visiting Nurse	0	C		0	0	
5.00	Other Nurse	487, 801	C	487, 80	01 0	487, 801	5. 00
6.00	Clinical Psychologist	0	C		0	0	
7. 00	Clinical Social Worker	88, 336	C	88, 33	0	88, 336	
8. 00	Laboratory Techni ci an	0	C		0	0	
9. 00	Other Facility Health Care Staff Costs	570, 660	C	570, 66		570, 660	
10.00	Subtotal (sum of lines 1 through 9)	3, 780, 276	26, 751	3, 807, 02	-137, 608		
11. 00	Physician Services Under Agreement	0	C)	0	0	
12.00	Physician Supervision Under Agreement	0	C)	0	0	
13.00	Other Costs Under Agreement	0	C)	0	0	10.00
14.00	Subtotal (sum of lines 11 through 13)	0	())	0 0	0	
15.00	Medical Supplies	0	204, 321	204, 32	21 0	204, 321	
16.00	Transportation (Health Care Staff)	0	(0	0	
17.00	Depreciation-Medical Equipment	0	(0	0	1
18.00	Professional Liability Insurance	0	(0	0	10.00
19.00		U	C	7	0	0	1
20.00	Allowable GME Costs		204 221	204.20		204 221	20.00
21.00	Subtotal (sum of lines 15 through 20)	2 700 274	204, 321	1		204, 321	
22. 00	Total Cost of Health Care Services (sum of	3, 780, 276	231, 072	4, 011, 34	-137, 608	3, 873, 740	22.00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00		٥		1	0 0	0	23. 00
24. 00	Dental	o O			0 0	0	
25. 00	1	O O			0	0	
25. 00	Optometry Telehealth	o O			0 0	0	
25. 01	1	o O			0	0	
26. 00	All other nonreimbursable costs	0			0	0	
27. 00	Nonallowable GME costs	٩	C	ή	٥	0	27.00
28. 00	1		(0 0	0	
20.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	Ч	C	Ί			20.00
	FACILITY OVERHEAD						1
29 00	Facility Costs	ol	663, 390	663, 39	00	663, 390	29 00
	Administrative Costs	1 215 781	1 478 641				

1, 215, 781

1, 215, 781

4, 996, 057

663, 390 1, 552, 692 2, 216, 082

6, 089, 822

30.00

31.00

32.00

663, 390 2, 694, 422

3, 357, 812

7, 369, 160

-1, 141, 730

-1, 141, 730

-1, 279, 338

1, 478, 641 2, 142, 031

2, 373, 103

30.00 Administrative Costs

31.00

32.00

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Peri od: From 01/01/2022	Worksheet M-1
	Component CCN: 15-8520	To 12/31/2022	Date/Time Prepared: 5/26/2023 3:03 pm
		DUIG I	0 1

			Component	CCN. 13-6520	10	12/31/2022	5/26/2023 3:0	
						RHC I	Cost	
		Adjustments	Net Expenses					
		,	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	1, 936, 433					1.00
2.00	Physician Assistant	0	0)				2.00
3.00	Nurse Practitioner	0	586, 189)				3.00
4.00	Visiting Nurse	0	0)				4.00
5.00	Other Nurse	0	487, 801					5. 00
6.00	Clinical Psychologist	0	0)				6. 00
7.00	Clinical Social Worker	0	88, 336)				7. 00
8.00	Laboratory Techni ci an	0	0					8. 00
9.00	Other Facility Health Care Staff Costs	0	570, 660					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	3, 669, 419)				10.00
11.00	Physician Services Under Agreement	0	0					11.00
12.00	Physician Supervision Under Agreement	0	0					12.00
13.00	Other Costs Under Agreement	0	0					13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0					14.00
15.00	Medical Supplies	0	204, 321					15.00
16.00	Transportation (Health Care Staff)	0	0					16.00
17.00	Depreciation-Medical Equipment	0	0					17.00
18.00	Professional Liability Insurance	0	0					18.00
19.00	Other Health Care Costs	0	0					19.00
20.00	Allowable GME Costs							20.00
21.00	Subtotal (sum of lines 15 through 20)	0	204, 321					21.00
22.00	Total Cost of Health Care Services (sum of	0	3, 873, 740					22.00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0)				23. 00
24.00	Dental	0	0)				24.00
25.00	Optometry	0	0)				25.00
25. 01	Tel eheal th	0	0)				25. 01
25. 02	Chronic Care Management	0	0)				25. 02
26.00	All other nonreimbursable costs	0	0)				26. 00
27. 00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0)				28. 00
	through 27)							
	FACILITY OVERHEAD							
29. 00	, ,	-294, 230	369, 160	1				29. 00
30. 00	Administrative Costs	-96, 523	1, 456, 169					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-390, 753	1, 825, 329	'				31.00
	30)							
32. 00	Total facility costs (sum of lines 22, 28	-390, 753	5, 699, 069	'				32. 00
	and 31)	ļ		I				1

Heal th	Financial Systems H	ENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
					From 01/01/2022		
			Component	CCN: 15-8525	To 12/31/2022		
					RHC II	5/26/2023 3:0 Cost	3 piii
		Compensation	Other Costs	Total (col 1	Reclassificat	Recl assi fi ed	
		Compensation	Other Costs	+ col . 2)	ions	Trial Balance	
				1 (01. 2)	1 0113	(col. 3 +	
						col . 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1					
1.00	Physi ci an	4, 772, 567	73, 676	4, 846, 24	3 0	4, 846, 243	1.00
2. 00	Physician Assistant	0	0	, , , , , ,	0	0	2.00
3.00	Nurse Practitioner	2, 264, 038	0	2, 264, 03	8 137, 608	2, 401, 646	
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	360, 231	0	360, 23	1 0	360, 231	5.00
6.00	Clinical Psychologist	o	0		0 0	0	6.00
7.00	Clinical Social Worker	90, 754	0	90, 75	4 0	90, 754	7.00
8.00	Laboratory Techni ci an	O	0		0	0	8.00
9.00	Other Facility Health Care Staff Costs	1, 261, 505	0	1, 261, 50	5 0	1, 261, 505	9.00
10.00	Subtotal (sum of lines 1 through 9)	8, 749, 095	73, 676	8, 822, 77	1 137, 608	8, 960, 379	10.00
11.00	Physician Services Under Agreement	O	0		0	0	11.00
12.00	Physician Supervision Under Agreement	o	0		0	0	12.00
13.00	Other Costs Under Agreement	o	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
15.00	Medical Supplies	0	446, 000	446, 00	0	446, 000	15.00
16.00	Transportation (Health Care Staff)	0	0		0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0	0	17.00
	Professional Liability Insurance	0	0		0	0	1
	Other Health Care Costs	0	0		0	0	19.00
	Allowable GME Costs						20.00
	Subtotal (sum of lines 15 through 20)	0	446, 000	446, 00	0	446, 000	
22. 00	Total Cost of Health Care Services (sum of	8, 749, 095	519, 676	9, 268, 77	1 137, 608	9, 406, 379	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES				_		
23. 00	Pharmacy	0	0		0	0	
24. 00	Dental	0	0		0	0	
	Optometry	0	0		0	0	
25. 01	Tel eheal th	0	0		0	0	
25. 02	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	=0.00
27. 00	Nonallowable GME costs						27. 00

887, 706

887, 706

9, 636, 801

0

-1, 985, 353

-1, 985, 353

-1, 847, 745

1, 511, 047

3, 409, 282

4, 920, 329

14, 189, 100

1, 511, 047

2, 521, 576

4, 032, 623

4, 552, 299

0 28.00

29.00

30.00

31.00

32.00

1, 511, 047 1, 423, 929

2, 934, 976

12, 341, 355

28.00 Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

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

through 27)
FACILITY OVERHEAD
29.00 Facility Costs

31.00

32.00

30.00 Administrative Costs

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-0030	Period: From 01/01/2022	Worksheet M-1
	Component CCN: 15-8525		Date/Time Prepared: 5/26/2023 3:03 pm

Adjustments
FACILITY HEALTH CARE STAFF COSTS
Allocation (col. 5 + col. 6) 6.00 7.00
Cool
FACILITY HEALTH CARE STAFF COSTS
FACILITY HEALTH CARE STAFF COSTS 1.00 Physician Assistant 0 0 2.00 2.401,646 3.00 4.00 4.00 4.00 0 4.00 0 0 0 0 0 0 0 0 0
FACILITY HEALTH CARE STAFF COSTS
1. 00 Physician -1,502,442 3,343,801 1.00 2. 00 Physician Assistant 0 0 2.00 3. 00 Nurse Practitioner 0 2,401,646 3.00 4. 00 Visiting Nurse 0 0 4.00 5. 00 Other Nurse 0 360,231 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 90,754 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 1, 261, 505 9.00 10. 00 Subtotal (sum of lines 1 through 9) -1, 502, 442 7, 457, 937 10.00 11. 00 Physician Services Under Agreement 0 0 11.00 12. 00 Physician Supervision Under Agreement 0 0 12.00 13. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 0 15. 00 Medical Supplies 0
2. 00 Physician Assistant 0 0 0 3.00 0 0 3.00 3.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 7.00 6.00 7.00 8.00 7.00 8.00 9.07 7.00 8.00 9.00 7.00 8.00 9.00 90.754 9.00
3. 00 Nurse Practitioner 0 2, 401, 646 3.00 4. 00 Visiting Nurse 0 0 4.00 5. 00 Other Nurse 0 360, 231 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 90,754 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 1, 261, 505 9.00 10. 00 Subtotal (sum of lines 1 through 9) -1, 502, 442 7, 457, 937 10.00 11. 00 Physician Services Under Agreement 0 0 11.00 12. 00 Physician Supervision Under Agreement 0 0 12.00 13. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 14.00 15. 00 Medical Supplies 0 446,000 15.00 16. 00 Transportation (Health Care Staff) 0 16.00
4. 00 Visiting Nurse 0 0 4.00 5. 00 Other Nurse 0 360, 231 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 90,754 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 1, 261, 505 9.00 10. 00 Subtotal (sum of lines 1 through 9) -1, 502, 442 7, 457, 937 10.00 11. 00 Physician Services Under Agreement 0 0 11.00 12. 00 Physician Supervision Under Agreement 0 0 12.00 13. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 14.00 15. 00 Medical Supplies 0 446,000 15.00 16. 00 Transportation (Health Care Staff) 0 16.00
5. 00 Other Nurse 0 360, 231 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 90, 754 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 1, 261, 505 9.00 10. 00 Subtotal (sum of lines 1 through 9) -1, 502, 442 7, 457, 937 10.00 11. 00 Physician Services Under Agreement 0 0 11.00 12. 00 Physician Supervision Under Agreement 0 0 12.00 13. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 0 15. 00 Medical Supplies 0 446,000 15.00 16. 00 Transportation (Health Care Staff) 0 0
6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 90,754 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 1, 261, 505 9.00 10. 00 Subtotal (sum of lines 1 through 9) -1, 502, 442 7, 457, 937 10.00 11. 00 Physician Services Under Agreement 0 0 11.00 12. 00 Physician Supervision Under Agreement 0 0 12.00 13. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 0 15. 00 Medical Supplies 0 446,000 15.00 16. 00 Transportation (Health Care Staff) 0 16.00
7. 00 Clinical Social Worker 0 90,754 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 1, 261, 505 9.00 10. 00 Subtotal (sum of lines 1 through 9) -1,502,442 7, 457, 937 10.00 11. 00 Physician Services Under Agreement 0 0 11.00 12. 00 Physician Supervision Under Agreement 0 0 12.00 13. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 0 15. 00 Medical Supplies 0 446,000 15.00 16. 00 Transportation (Health Care Staff) 0 16.00
8. 00 Laboratory Technician 0 0 8. 00 9. 00 Other Facility Health Care Staff Costs 0 1, 261, 505 9. 00 10. 00 Subtotal (sum of lines 1 through 9) -1,502, 442 7, 457, 937 10. 00 11. 00 Physician Services Under Agreement 0 0 11. 00 12. 00 Physician Supervision Under Agreement 0 0 12. 00 13. 00 Other Costs Under Agreement 0 0 13. 00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 0 15. 00 Medical Supplies 0 446,000 15. 00 16. 00 Transportation (Health Care Staff) 0 16. 00
9. 00 Other Facility Health Care Staff Costs 0 1, 261, 505 9. 00 10. 00 Subtotal (sum of lines 1 through 9) -1, 502, 442 7, 457, 937 10. 00 11. 00 Physician Services Under Agreement 0 0 11. 00 12. 00 Physician Supervision Under Agreement 0 0 12. 00 13. 00 Other Costs Under Agreement 0 0 13. 00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 14. 00 15. 00 Medical Supplies 0 446, 000 15. 00 16. 00 Transportation (Health Care Staff) 0 16. 00
10.00 Subtotal (sum of lines 1 through 9) -1,502,442 7,457,937 10.00 11.00 Physician Services Under Agreement 0 0 12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 446,000 16.00 Transportation (Health Care Staff) 0 16.00
11.00 Physician Services Under Agreement 0 0 12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 446,000 16.00 Transportation (Health Care Staff) 0 0
12.00 Physician Supervision Under Agreement 0 0 12.00 13.00 Other Costs Under Agreement 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 0 14.00 15.00 Medical Supplies 0 446,000 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00
13.00 Other Costs Under Agreement 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 0 14.00 15.00 Medical Supplies 0 446,000 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00
14.00 Subtotal (sum of lines 11 through 13) 0 0 14.00 15.00 Medical Supplies 0 446,000 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00
15.00 Medical Supplies 0 446,000 15.00 Transportation (Health Care Staff) 0 0 16.00
16.00 Transportation (Health Care Staff) 0 0 16.00
17.00 Depreciation-Medical Equipment 0 0 17.00
18.00 Professional Liability Insurance 0 0 18.00
19.00 Other Health Care Costs 0 0 19.00
20.00 Allowable GME Costs 20.00
21.00 Subtotal (sum of lines 15 through 20) 0 446,000 21.00
22.00 Total Cost of Health Care Services (sum of -1,502,442 7,903,937 22.00
lines 10, 14, and 21)
COSTS OTHER THAN RHC/FQHC SERVICES
23. 00 Pharmacy 0 0 23. 00
24. 00 Dental 0 0 24. 00
25. 00 Optometry 0 0 25. 00
25. 01 Tel eheal th 0 0 25. 01
25. 02 Chronic Care Management 0 0 25. 02
26. 00 All other nonreimbursable costs 0 0 26. 00
27. 00 Nonal Lowable GME costs 27. 00
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 28.00
through 27)
FACILITY OVERHEAD
29. 00 Facility Costs -675, 345 835, 702 29. 00
30. 00 Admi ni strati ve Costs -24, 234 1, 399, 695 30. 00
31.00 Total Facility Overhead (sum of lines 29 and -699,579 2,235,397 31.00
30)
32.00 Total facility costs (sum of lines 22, 28 -2,202,021 10,139,334 32.00
and 31)

Heal th	Financial Systems HE	NRY COUNTY MEM	IORI AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
					From 01/01/2022 To 12/31/2022		
			component	CCN: 15-8556	To 12/31/2022	Date/Time Pre 5/26/2023 3:0	epared:
					RHC III	Cost	о рііі
		Compensation	Other Costs	Total (col.	Reclassificat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	421, 251	5, 744	426, 99		426, 995	1.00
2.00	Physici an Assistant	0	0		0	0	2.00
3.00	Nurse Practitioner	284, 795	0	284, 79		284, 795	
4.00	Visiting Nurse	0	0		0	0	
5. 00	Other Nurse	89, 699	0	89, 69	9 0	89, 699	1
6.00	Clinical Psychologist	0	0		0	0	
7. 00	Clinical Social Worker	0	0		0	0	,
8. 00	Laboratory Techni ci an	0	0		0	0	0.00
9. 00	Other Facility Health Care Staff Costs	151, 610		151, 61		151, 610	
10.00	Subtotal (sum of lines 1 through 9)	947, 355	5, 744	953, 09		953, 099	1
11.00	Physician Services Under Agreement	0	0		0	1	
12.00	Physician Supervision Under Agreement	0	0		0		1
13.00	Other Costs Under Agreement	0	0		0	0	1
14. 00 15. 00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	49, 219	49, 21	9 0	0	
16.00	Transportation (Health Care Staff)	0	49, 219	49, 21	0 0	49, 219 0	
17. 00	Depreciation-Medical Equipment	0	0		0	0	1
18. 00	Professional Liability Insurance	0			0	0	18.00
19. 00	Other Health Care Costs	0			0 0		1
20.00	Allowable GME Costs		Ĭ				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	49, 219	49, 21	9 0	49, 219	
22. 00	Total Cost of Health Care Services (sum of	947, 355				·	
22.00	lines 10, 14, and 21)	, , , , , , ,	0 1, 700	1,002,01		1,002,010	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES	l					1
23.00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25. 00
25. 01	Tel eheal th	0	0		0 0	0	25. 01
25. 02	Chronic Care Management	0	0		0 0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28. 00
	through 27)	1	1	1	1	I .	1

105, 958

105, 958

1, 053, 313

219, 119

330, 448

549, 567

604, 530

219, 119

436, 406

655, 525

1, 657, 843

-179, 005

-179, 005

-179, 005

219, 119 257, 401 476, 520

1, 478, 838

29.00

30.00

31.00

32.00

through 27)
FACILITY OVERHEAD
29.00 Facility Costs

31.00

32.00

30.00 Administrative Costs

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-0030	Peri od: From 01/01/2022	Worksheet M-1
	Component CCN: 15-8556	To 12/31/2022	

			Component	CCN: 15-8556	То	12/31/2022	Date/Time Pro 5/26/2023 3:0	
						RHC III	Cost	
	·	Adjustments	Net Expense	5				
		,	for					
			All ocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	426, 9	95				1.00
2.00	Physician Assistant	0		0				2.00
3.00	Nurse Practitioner	0	284, 79	95				3. 00
4.00	Visiting Nurse	o		o				4.00
5.00	Other Nurse	o	89, 69	99				5. 00
6.00	Clinical Psychologist	ol		ol				6.00
7.00	Clinical Social Worker	ol		ol				7.00
8.00	Laboratory Techni ci an	ol		ol				8.00
9. 00	Other Facility Health Care Staff Costs	0	151, 6	10				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	953, 0	99				10.00
11. 00	Physician Services Under Agreement	ol		0				11.00
12. 00	Physician Supervision Under Agreement	ol		0				12.00
	Other Costs Under Agreement	ol		0				13.00
14. 00	Subtotal (sum of lines 11 through 13)	0		o				14.00
15. 00	Medical Supplies	Ö	49, 2					15.00
16. 00	Transportation (Health Care Staff)	0	77,2	0				16.00
17. 00		0		0				17.00
18. 00	Professional Liability Insurance	0		0				18.00
	Other Health Care Costs	0		0				19.00
20. 00	Allowable GME Costs	ď		٩				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	49, 2	10				21.00
22. 00	Total Cost of Health Care Services (sum of	0	1, 002, 3	•				22.00
22.00	lines 10, 14, and 21)	ď	1,002,3	10				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23 00	Pharmacy	O		0				23. 00
24. 00	Dental	ol Ol		0				24.00
25. 00	Optometry	0		0				25. 00
25. 01	Tel eheal th	0		0				25. 01
25. 01	4	0		0				25. 02
26. 00	All other nonreimbursable costs	0						26.00
27. 00	Nonallowable GME costs	٩		٩				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23			0				28.00
26.00	through 27)	٩		٩				20.00
	FACILITY OVERHEAD							+
20 00	Facility Costs	-78, 769	140, 3	50				29. 00
30.00	Administrative Costs	-76, 769 -38, 776	218, 6	1				30.00
31. 00	4		218, 6. 358, 9					31.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-117, 545	ააგ, 9	, 5				31.00
32. 00	Total facility costs (sum of lines 22, 28	-117, 545	1, 361, 2	23				32.00
32.00	and 31)	-117, 545	1, 301, 2	, ,				32.00
	juna 01)	ı		I				1

Heal th	Financial Systems HE	ENRY COUNTY MEM	MORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
					RHC I	Cost	<u>o p</u>
	·	Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Positions Positions		1				
1. 00	Physi ci an	4. 44			1 4		1.00
2.00	Physician Assistant	0. 47	,		1 0		2.00
3. 00	Nurse Practitioner	3. 49			1 3		3.00
4.00	Subtotal (sum of lines 1 through 3)	8. 40			7	15, 295	
5.00	Visiting Nurse	0.00				0	5.00
6. 00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.83	l .			677	7.00
7. 01 7. 02	Medical Nutrition Therapist (FQHC only)	0. 00 0. 00				0	7. 01 7. 02
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			U	7.02
8. 00	Total FTEs and Visits (sum of lines 4	9. 23	15, 972			15, 972	8.00
0.00	through 7)	7. 23	15, 772			15, 772	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
7.00	ringer en an eer trees en acr rigi eemente					-	71.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEI	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			3, 873, 740	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s					3, 873, 740	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		1, 825, 329	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			4, 493, 947	
16. 00	Total overhead (sum of lines 14 and 15)					6, 319, 276	
	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					6, 319, 276	
	Overhead applicable to hospital-based RHC/FC					6, 319, 276	
∠0. 00	Total allowable cost of hospital-based RHC/F	UHC SERVICES (sum of lines 10	u and 19)		10, 193, 016	20.00

Heal th	Financial Systems HI	ENRY COUNTY MEN	MORIAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC :	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component	CCN: 15-8525	From 01/01/2022 To 12/31/2022	Date/Time Pre	norod.
			Component	CCN: 15-8525	To 12/31/2022	5/26/2023 3:0	
					RHC II	Cost	<u>o p</u>
		Number of FTE	Total Visits	Producti vi ty	/ Mi ni mum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Positions		T	T			
1. 00	Physi ci an	8. 32		1	1 8		1.00
2. 00	Physician Assistant	0.00		1	1 0		2.00
3.00	Nurse Practitioner	13. 29			1 13	04 405	3.00
4.00	Subtotal (sum of lines 1 through 3)	21. 61		i	21	31, 195	
5.00	Visiting Nurse	0.00		1		0	
6.00	Clinical Psychologist	0.00				0	0.00
7.00	Clinical Social Worker	1. 24	l .	1		910 0	
7. 01 7. 02	Medical Nutrition Therapist (FQHC only) Diabetes Self Management Training (FQHC	0. 00 0. 00	l .			0	
7.02	only)	0.00				U	7.02
8. 00	Total FTEs and Visits (sum of lines 4	22. 85	32, 105			32, 105	8.00
0.00	through 7)	22.03	32, 103			32, 103	0.00
9.00	Physician Services Under Agreements		0	,		0	9.00
	<u> </u>						
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEI	RVI CES			
	Total costs of health care services (from Wk					7, 903, 937	10.00
	Total nonreimbursable costs (from Wkst. M-1,					0	11.00
	Cost of all services (excluding overhead) (s					7, 903, 937	
	Ratio of hospital-based RHC/FQHC services (I					1. 000000 2, 235, 397	
14.00							
	Parent provider overhead allocated to facili	ty (see instru	ctions)			8, 795, 344	
16. 00	Total overhead (sum of lines 14 and 15)					11, 030, 741	
	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16		40	40)		11, 030, 741	
	Overhead applicable to hospital-based RHC/FC					11, 030, 741	
∠∪. ∪∪	Total allowable cost of hospital-based RHC/F	runc services (Sum of tines to	o and 19)		18, 934, 678	J 20.00

		ENRY COUNTY MEN	MORIAL HOSPITAL			u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC :	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre	nonod.
			Component	CCN: 15-8556	10 12/31/2022	5/26/2023 3:0	
					RHC III	Cost	<u> </u>
		Number of FTE	Total Visits	Producti vi ty	Minimum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Positions Positions						
1. 00	Physi ci an	1.05			1 1		1.00
2.00	Physician Assistant	0. 23			1 0		2.00
3. 00	Nurse Practitioner	1. 55			1 2		3. 00
4.00	Subtotal (sum of lines 1 through 3)	2. 83			3	4, 119	
5.00	Visiting Nurse	0.00				0	
6.00	Clinical Psychologist	0.00				0	
7.00	Clinical Social Worker	0.00				0	
7. 01 7. 02	Medical Nutrition Therapist (FOHC only)	0.00				0	
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8. 00	Total FTEs and Visits (sum of lines 4	2. 83	4, 119			4, 119	8.00
0.00	through 7)	2.03	4, 117			4, 117	0.00
9. 00	Physician Services Under Agreements		0			0	9.00
7.00	Triyst of all services offact rigit coments					Ü	7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEI	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			1, 002, 318	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			1, 002, 318	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1. 000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet.	M-1, col. 7, li	ine 31)		358, 975	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			1, 040, 152	15.00
16.00	Total overhead (sum of lines 14 and 15)					1, 399, 127	
	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					1, 399, 127	
	Overhead applicable to hospital-based RHC/FC	,		,		1, 399, 127	
20.00	Total allowable cost of hospital-based RHC/F	·QHC services (sum of lines 10	o and 19)		2, 401, 445	20.00

	Financial Systems HENRY COUNTY MEMORI			u of Form CMS-2	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0030	Peri od: From 01/01/2022	Worksheet M-3	
SERVI (ES	Component CCN: 15-8520	To 12/31/2022	Date/Time Pre	pared:
				5/26/2023 3:0	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		10, 193, 016	1.00
2.00	Cost of injections/infusions and their administration (from W	/kst. M-4, line 15)		350, 753	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m	ninus line 2)		9, 842, 263	3.00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			15, 972	4.00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
6. 00	Total adjusted visits (line 4 plus line 5)			15, 972	
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal aul ati an	616. 22	7.00
			Cal cul ati on	OF LIMIT (1)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2022	
				through	
			1.00	12/31/2022)	
9 00	Por visit payment Limit (from CMS Dub. 100 04 chapter 0, 820	1 4 or your contractor)	1.00	2.00	9 00
8. 00 9. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	o. 6 or your contractor)	0. 00 0. 00	419. 97 419. 97	8. 00 9. 00
7. 00	CALCULATION OF SETTLEMENT		0.00	417. 77	7.00
10. 00	Program covered visits excluding mental health services (from	contractor records)	0	5, 437	10.00
11. 00	Program cost excluding costs for mental health services (line		0	2, 283, 377	11.00
12.00	Program covered visits for mental health services (from contr	actor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x li	•	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions		0	0	
15.00	Graduate Medical Education Pass Through Cost (see instruction	*		0 000 077	15.00
16. 00 16. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	2, 283, 377	
16. 01	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov	•		1, 061, 670 170, 527	
16. 03	Total program preventive charges (see First detroils) (110m prov Total program preventive costs ((line 16.02/line 16.01) times	•		366, 758	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0			1, 449, 435	
	(Titles V and XIX see instructions.)			.,,	
16. 05	Total program cost (see instructions)		0	1, 816, 193	16. 05
17. 00	Primary payer amounts			0	
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		104, 825	18. 00
10 00	records)	una) (from contractor		157 0/4	10 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (110m contractor		157, 264	19.00
20. 00	Net Medicare cost excluding vaccines (see instructions)			1, 816, 193	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		96, 868	l
22. 00	Total reimbursable Program cost (line 20 plus line 21)			1, 913, 061	22.00
23. 00	Allowable bad debts (see instructions)			0	
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24.00		ructions)		0	
∠5. UU	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ve)		0	25.00
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	13)		0	
	Net reimbursable amount (see instructions)			1, 913, 061	
26. 01	Sequestration adjustment (see instructions)			24, 105	1
	1 '			0	
26. 02				1, 736, 962	27.00
26. 02 27. 00	T1-11		1	0	28.00
27. 00 28. 00	,				
27. 00	Balance due component/program (line 26 minus lines 26.01, 26.	•		151, 994 0	

	Financial Systems HENRY COUNTY MEMORI			u of Form CMS-2	
CALCUL SERVI C	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0030	Peri od: From 01/01/2022	Worksheet M-3	
SERVIC	ES	Component CCN: 15-8525	To 12/31/2022	Date/Time Pre	pared:
		·		5/26/2023 3:0	3 pm
		Title XVIII	RHC II	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		18, 934, 678	1.00
2. 00	Cost of injections/infusions and their administration (from W	kst. M-4, line 15)		1, 914, 182	2. 00
3. 00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		17, 020, 496	1
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	11.		32, 105	
5. 00 6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	Tine 9)		0 32, 105	5. 00 6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			530. 15	ı
7.00	hajastea cost per visit (iiile 3 dividea by iiile 0)		Cal cul ati on		7.00
			our cur a tr on	01 21 (1)	
				Rate Period 1	
			N/A	(01/01/2022	
				through	
			1. 00	12/31/2022) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or vour contractor)	0.00	306. 47	8.00
9. 00	Rate for Program covered visits (see instructions)	,	0.00	306. 47	9.00
	CALCULATION OF SETTLEMENT				
10. 00	Program covered visits excluding mental health services (from		0	6, 941	10.0
11.00	Program cost excluding costs for mental health services (line	•	0	2, 127, 208	
12.00	Program covered visits for mental health services (from contr		0	0	12.00
13. 00 14. 00	Program covered cost from mental health services (line 9 x li Limit adjustment for mental health services (see instructions	*	0	0	13. 00 14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instruction	•		O	15.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	2, 127, 208	
16. 01	Total program charges (see instructions)(from contractor's re	cords)		1, 551, 586	16. 0°
16. 02	Total program preventive charges (see instructions)(from prov	•		362, 326	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		496, 746	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		1, 168, 136	16.04
16. 05	Total program cost (see instructions)		0	1, 664, 882	16. 05
17. 00	Primary payer amounts			95	
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		170, 292	18.00
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		203, 778	19.00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			1, 664, 787	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		264, 819	ı
22. 00	Total reimbursable Program cost (line 20 plus line 21)	1, 11116 10)		1, 929, 606	
23. 00	Allowable bad debts (see instructions)			0	
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 0°
	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	
	Pioneer ACO demonstration payment adjustment (see instruction	S)		0	l
25. 99 26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 1, 929, 606	
26. 01	Sequestration adjustment (see instructions)			24, 313	1
26. 02	Demonstration payment adjustment amount after sequestration			0	
27. 00	Interim payments			1, 562, 629	
28. 00	Tentative settlement (for contractor use only)			0	28.00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.			342, 664	
30. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II	,	0	30.00

	inancial Systems HENRY COUNTY MEMORI			u of Form CMS-2	
	ION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0030	Peri od: From 01/01/2022	Worksheet M-3	
SERVI CES		Component CCN: 15-8556	To 12/31/2022	Date/Time Pre	pared:
		·		5/26/2023 3:0	
		Title XVIII	RHC III	Cost	1
				1. 00	
DF	TERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
	otal Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		2, 401, 445	1.0
2. 00 Co	ost of injections/infusions and their administration (from W	/kst. M-4, line 15)		66, 931	2.0
3. 00 To	otal allowable cost excluding injections/infusions (line 1 m	inus line 2)		2, 334, 514	3.0
4. 00 To	otal Visits (from Wkst. M-2, column 5, line 8)			4, 119	4.0
	hysicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
1	otal adjusted visits (line 4 plus line 5)			4, 119	
7. 00 Ac	djusted cost per visit (line 3 divided by line 6)		0.1	566. 77	7.00
			Cal cul ati on	OT LIMIT (I)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2022	
				through	
				12/31/2022)	
0.00	and the second limit (from CNC Dub. 100 04 about a 2 CCC		1.00	2. 00	0.00
	er visit payment limit (from CMS Pub. 100-04, chapter 9, §20	. 6 or your contractor)	0. 00 0. 00	414. 55	
	ate for Program covered visits (see instructions) ALCULATION OF SETTLEMENT		0.00	414. 55	9.00
	rogram covered visits excluding mental health services (from	contractor records)	0	1, 265	10.00
	rogram cost excluding costs for mental health services (line		o	524, 406	
1	rogram covered visits for mental health services (from contr	•	0	0	12.0
13. 00 Pr	rogram covered cost from mental health services (line 9 x li	ne 12)	0	0	13.00
14. 00 Li	imit adjustment for mental health services (see instructions	5)	0	0	14.00
15. 00 Gr	raduate Medical Education Pass Through Cost (see instruction	s)			15.00
1	otal Program cost (sum of lines 11, 14, and 15, columns 1, 2	*	0	524, 406	
	otal program charges (see instructions)(from contractor's re			269, 259	
1	otal program preventive charges (see instructions)(from prov	•		84, 773	
	otal program preventive costs ((line 16.02/line 16.01) times otal Program non-preventive costs ((line 16 minus lines 16.0	*		165, 103 268, 514	
	Titles V and XIX see instructions.)	and roj trilles . 60)		200, 514	10.0
	otal program cost (see instructions)		0	433, 617	16. 0!
1	rimary payer amounts			0	17.00
	ess: Beneficiary deductible for RHC only (see instructions)	(from contractor		23, 660	18.00
1	ecords)				
	eneficiary coinsurance for RHC/FQHC services (see instructio	ns) (from contractor		32, 165	19.00
	ecords) et Medicare cost excluding vaccines (see instructions)			433, 617	20.00
	rogram cost of vaccines and their administration (from Wkst.	M-4 line 16)		24, 304	1
	otal reimbursable Program cost (line 20 plus line 21)	,		457, 921	
	Howable bad debts (see instructions)			0	1
23. 01 Ac	djusted reimbursable bad debts (see instructions)			0	23. 0°
	lowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		0	
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	oneer ACO demonstration payment adjustment (see instruction	s)		0	l
1	emonstration payment adjustment amount before sequestration			457,001	1
1	et reimbursable amount (see instructions)			457, 921	
	equestration adjustment (see instructions) emonstration payment adjustment amount after sequestration			5, 770 0	
1	nterim payments			414, 900	
1	entative settlement (for contractor use only)			414, 700 N	28.00
1	alance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		37, 251	
	rotested amounts (nonallowable cost report items) in accorda		,	0	1
	hapter I, §115.2		1	· ·	1

Heal th	Financial Systems HENRY COUNTY MEM	MORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co	CN: 15-0030	Peri od:	Worksheet M-4	
		Component	CCN: 15-8520	From 01/01/2022 To 12/31/2022		pared:
		T: 11	V0/11-1	DUO I	5/26/2023 3:0	3 pm
		PNEUMOCOCCAL	XVIII INFLUENZA	RHC I COVI D-19	Cost MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3, 669, 419		· · · · · · · · · · · · · · · · · · ·		1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000166	0. 00239	0. 000000	0.000000	2. 00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	609	8, 78	0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	10, 492	113, 41	4 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	11, 101	122, 19	9 0	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3, 873, 740	3, 873, 74	0 3, 873, 740	3, 873, 740	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	6, 319, 276	6, 319, 27	6, 319, 276	6, 319, 276	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 002866	0. 03154	0. 000000	0.000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	18, 111	199, 34	2 0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	29, 212	321, 54	.1 0	0	10.00
11. 00	Total number of injections/infusions (from your records)	58			0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	503. 66				
13. 00	Number of injection/infusion administered to Program beneficiaries	23	22	0	0	13.00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13	11, 584	85, 28	0	0	14.00
	and 13.01, as applicable)					
					COST OF	
					INJECTIONS /	
					INFUSIONS AND ADMINISTRATIO	
					N N	
				1. 00	2.00	
15. 00			f columns 1,		350, 753	15. 00
1/ 00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		- (6		0/ 0/0	1/ 00
16. 00	Total Program cost of injections/infusions and their admin columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou				96, 868	16.00
	1, 2, 2.01, and 2.02, 11116 14) (transfer this amou	III LU WKSL. W-	5, 11116 21)	I	ı	

Heal th	Financial Systems HENRY COUNTY MEN	MORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provi der CO	CN: 15-0030	Peri od: From 01/01/2022	Worksheet M-4	
		Component	CCN: 15-8525	To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
			XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	7, 457, 937	7, 457, 93	7, 457, 937	7, 457, 937	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 001893	0. 00390	0. 002499	0.000000	2.00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	14, 118	29, 1	18, 637	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	289, 440	447, 69	92 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	303, 558	476, 8	15 18, 637	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	7, 903, 937	7, 903, 93	7, 903, 937	7, 903, 937	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	11, 030, 741	11, 030, 7	11, 030, 741	11, 030, 741	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 038406	0. 06033	0. 002358	0.000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	423, 647	665, 48		0	9. 00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	727, 205		·	0	10. 00
11. 00	Total number of injections/infusions (from your records)	1, 600				11.00
12. 00	Cost per injection/infusion (line 10/line 11)	454. 50			0.00	
13. 00	Number of injection/infusion administered to Program beneficiaries	114	58	39 443		13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	51, 813	203, 64	9, 365	0	14.00
	Tand 13.01, as appricable)				COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMINISTRATIO	
					N	
				1. 00	2. 00	
	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			1, 914, 182	
16. 00	Total Program cost of injections/infusions and their admin				264, 819	16. 00
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou	nt to Wkst. M-3	3, line 21)			

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC		Peri od: From 01/01/2022	Worksheet M-4	
		Component C	CCN: 15-8556	To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
			XVIII	RHC III	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	953, 099	953, 09	9 953, 099	953, 099	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000509	0. 00149	4 0. 000000	0.000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	485	1, 42	4 0	0	3.00
. 00	Injections/infusions and related medical supplies costs (from your records)	8, 141	17, 88	6 0	0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	8, 626	19, 31	0	0	5.00
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 002, 318	1, 002, 31	8 1, 002, 318	1, 002, 318	6.00
7. 00	Total overhead (from Wkst. M-2, line 19)	1, 399, 127	1, 399, 12	7 1, 399, 127	1, 399, 127	7.0
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 008606	0. 01926	5 0.000000	0.000000	8.00
0. 00	Overhead cost - injection/infusion (line 7 x line 8)	12, 041	26, 95	4 0	0	9.00
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	20, 667	46, 26	4 0	0	10.00
11.00	Total number of injections/infusions (from your records)	45	13			11.00
2.00	Cost per injection/infusion (line 10/line 11)		350. 4			12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	14	5	1 0	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0		
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	6, 430	17, 87	4 0	0	14.00
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI O	
				1 00	N 2.00	
5. 00	Total cost of injections / infusions and their administration	n costs (sum of	F columns 1	1.00	2. 00 66, 931	15. 00
5.00			COI UIIII IS 1,		00, 931	15.00
6. 00		injection/infusion staff time to total health on 0.000509 on 0.0014 on on on the original fitting on health care staff cost (line 1 x line on on the original fitting on the original fitting on on the original fitting o				16.00
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount	nt to Wkst. M-3	3. line 21)			1

Health Financial Systems	HENRY COUNTY MEMORIAL HO	SPI TAL	In Lieu	of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES			From 01/01/2022 To 12/31/2022	Date/Time Prep	pared:
				5/26/2023 3:03	3 pm
			RHC I	Cost	

Ref Part			Component Con. 13-8320	10 12/31/2022	5/26/2023 3: 0	
Total interim payments paid to hospital-based RHC/FOHC 1.00 2.00 1.736,962 1.736				RHC I		
Total interim payments paid to hospital-based RHC/FOHC 1.00 2.00 1,736,962 1,736				Par	rt B	
On Total Interim payments paid to hospital-based RRC/FDRC Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero. List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider On provider to Program Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) Disc Completed By Contractor Disc Completed By Contractor SETILEMENT To PROVIDER S				mm/dd/yyyy	Amount	
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Program to Provider O Provider to Program O Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) O Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) O O O O O O O O O O O O O				1.00	2. 00	
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Program to Provider O Provider to Program O Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) O Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) O O O O O O O O O O O O O	00	Total interim payments paid to hospital-based RHC/FQHC			1, 736, 962	1.
"NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider O Provider to Program O Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROVIDER SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) O D O D O D O D O D O D O D O D O D O	00		tted or to be submitted to		1	2.
"NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider O Provider to Program O Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROVIDER SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) O D O D O D O D O D O D O D O D O D O		the contractor for services rendered in the cost reporting	period. If none, write			
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Program to Provider Program to Provider Provider to Program Provider		revision of the interim rate for the cost reporting period.	Also show date of each			
Provider to Program Provider to Program Provider to Program O Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 1,736,962 27) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROVIDER SETILEMEN		payment. If none, write "NONE" or enter a zero. (1)				
Provider to Program		Program to Provider				
Provider to Program	1				0	3
Provider to Program O Provider to Program O Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) O Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider O Provider to Program O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM O Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr)	2				0	3
Provider to Program Provider to Program O Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) O Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Proyrider to Program O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) Number (Mo/Day/Yr) Number (Mo/Day/Yr) Number (Mo/Day/Yr) O 1.00 2.00	3				0	3
Provider to Program Provider to Program	4				0	3
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Provider to Program O 1 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROVIDER Total Medicare program liability (see instructions) O 1, 888,956 NPR Date (Mo/Day/Yr)	5				0	3
1		Provider to Program		<u> </u>		
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	0				0	3
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Provider to Program Provider to Program O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROGRAM Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr)	1				0	3
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Provider to Program O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) O SUBSTILEMENT TO PROGRAM Total Medicare program liability (see instructions) O SUBSTILEMENT TO PROGRAM Total Medicare program liability (see instructions) O SUBSTILEMENT TO PROGRAM Total Medicare program liability (see instructions) O SUBSTILEMENT TO PROGRAM Total Medicare program liability (see instructions) O SUBSTILEMENT TO PROGRAM Total Medicare program liability (see instructions)	2				0	3
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 2.7) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Provider to Program O Provider to Program O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) O Substant (Sum of lines 5.00-5.98) O Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) O Sumber (Mo/Day/Yr) O 1.00 2.00	3				0	3
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 2.7) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Provider to Program O Provider to Program O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) O Substant (Sum of lines 5.00-5.98) O Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) O Sumber (Mo/Day/Yr) O 1.00 2.00	4				0	3
Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Provider to Program Provider to Program O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) O 1, 888,956 NPR Date (Mo/Day/Yr) O 1.00 2.00	9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	. 98)		0	3
TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Provider to Program Provider to Program O ! Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) Contractor Number Number Number (Mo/Day/Yr) O 1.00 2.00	0	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	9	1, 736, 962	4
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider O Provider to Program O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) Number (Mo/Day/Yr) O 1.00 2.00		27)				
each payment. If none, write "NONE" or enter a zero. (1) Program to Provider O Provider to Program O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) O 1.00 O 1.0		TO BE COMPLETED BY CONTRACTOR			,	
Program to Provider Provider to Program Provider to Program Provider to Program O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) New Date (Mo/Day/Yr) O 1.00 2.00	0	List separately each tentative settlement payment after des	sk review. Also show date o	of		5
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00 1.00 1.00 2.00 1.00 1.00 2.00 1.00						
Provider to Program		Program to Provider				
Provider to Program	1				0	5
Provider to Program	2				0	5
0 0 0 0 0 0 0 0 0 0	3				0	5
0 9		Provider to Program				
2	0				1	5
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	1				1	5
Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00	2				-	5
SETTLEMENT TO PROVIDER	9				0	5
2 SETTLEMENT TO PROGRAM 2 Total Medicare program liability (see instructions)	0		e cost report. (1)			6
Total Medicare program liability (see instructions)	1					6
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	2					6
Number (Mo/Day/Yr) 0 1.00 2.00	0	Total Medicare program liability (see instructions)				7
0 1.00 2.00						
O Name of Contractor 8			0	1. 00	2. 00	
	00	Name of Contractor				8

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provi der CCN: 15-0030	Peri od: From 01/01/2022	Worksheet M-5
SERVICES RENDERED TO FROGRAM DENETTOTAL	(I L)	Component CCN: 15-8525		
			RHC II	Cost

		Component Con. 13-8323	10 12/31/2022	5/26/2023 3: 0	
			RHC II	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			1, 562, 629	1.0
2. 00	Interim payments payable on individual bills, either submit			0	2.0
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				3. (
	revision of the interim rate for the cost reporting period.	. Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3.
3. 02				0	3.
. 03				l ol	3.
3. 04				l ol	3.
3. 05				o	3.
	Provider to Program				ĺ
. 50				0	3.
. 51				l ol	3.
. 52				l ol	3.
. 53				l ol	3.
. 54				l ol	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	. 98)		l ol	3.
1. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			1, 562, 629	4.
	27)			, ,	
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				ĺ
. 01				0	5.
. 02				0	5.
. 03				0	5.
	Provider to Program				
. 50				0	5.
. 51				0	5.
. 52				0	5.
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	. 98)		o	5.
. 00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.
. 01	SETTLEMENT TO PROVIDER	, , ,		342, 664	6.
. 02	SETTLEMENT TO PROGRAM			0	6.
. 00	Total Medicare program liability (see instructions)			1, 905, 293	
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provider CCN: 15-00 Component CCN: 15-8	From 01/01/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 3:03 pm
			DUC III	Cost

		Component CCN: 15-8556		Date/Time Prep 5/26/2023 3:03	
		RHC/FOHC either submitted or to be submitted to ost reporting period. If none, write distinct amount based on subsequent orting period. Also show date of each object. (1) I ines 3.50-3.98) H 3.99) (transfer to Worksheet M-3, line distinct after desk review. Also show date of each object. (1)	RHC III	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
00	Total interim payments paid to hospital-based RHC/FQHC			414, 900	1.
00	Interim payments payable on individual bills, either submit	tted or to be submitted to		o	2.
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	•			
00	List separately each retroactive lump sum adjustment amount	t based on subsequent			3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		<u>'</u>		
01	- · · · · · · · · · · · · · · · · · · ·			0	3.
)2				ol	3.
)3				ol	3.
)4				0	3.
)5				0	3.
, 0	Provider to Program				0.
0	1 TOVI GCT TO TITOGI GIII			0	3.
1				l ol	3.
2				0	3.
3				0	3
4				0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	00)		0	3.
0				414, 900	4.
,0	27)	ster to worksheet w-s, ittle		414, 700	4.
	TO BE COMPLETED BY CONTRACTOR				
00		sk raviaw. Also show data o	of .		5.
,0	leach payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date of	71		٥.
	Program to Provider				
)1	1 rogram to 1 rovi dei			0	5.
)2				0	5.
3				0	5.
5	Provider to Program			0	٥.
0	11 OVI del 10 11 Ogi alli			0	5.
1				0	5.
2				0	5.
9	 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	00)		0	5
0	Determined net settlement amount (balance due) based on the			· ·	6.
1	SETTLEMENT TO PROVIDER	e cost report. (1)		37, 251	6.
2	SETTLEMENT TO PROVIDER			37, 231	6.
				_	
0	Total Medicare program liability (see instructions)		Contractor	452, 151 NPR Date	7.
			Contractor		
		0	Number	(Mo/Day/Yr) 2.00	
0	Name of Contractor	<u> </u>	1.00	2.00	0
00	Name of Contractor				8.