This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0030 Worksheet S Peri od: From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: 5/18/2020 9:36 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically filed cost report Date: 5/18/2020 9:36 am

Contractor use only

use only

] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low.

(5) Amended

] Manually submitted cost report

[1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[18] 17. Contractor's Vendor Code:
[18] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date: (3) Settled with Audit (4) Reopened

number of times reopened = 0-9.

## PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY 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 the Balance Sheet and Statement of Revenue and Expenses prepared by HENRY COUNTY MEMORIAL HOSPITAL (15-0030) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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.

[ X ]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

DARIN BROWN (Si gned)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Officer or Administrator of Provider(s)

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY							
1.00	Hospi tal	0	35, 127	16, 696	0	-132, 391	1. 00
2.00	Subprovi der - IPF	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	1		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		275, 065		0	10.00
10. 01	RURAL HEALTH CLINIC II	0		45, 979		0	10. 01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	Total	0	35, 127	337, 741	0	-132, 391	200. 00
The ab	ove amounts represent "due to" or "due from"	the applicable	program for th	ne element of t	he above comple	ex indicated.	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0030 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 5/18/2020 9:36 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1000 NORTH 16TH STREET 1.00 PO Box: 1.00 State: IN 2.00 City: NEW CASTLE Zi p Code: 47392-County: HENRY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) 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 3.00 HOSPI TAL Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA HCMH HOME CARE 157430 99915 06/14/1995 Ρ Ν 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 151564 99915 14.00 HOSP-BASED HOSPICE 08/31/1998 14.00 NEW CASTLE FAMILY AND Hospital-Based Health Clinic - RHC O 15.00 158520 99915 04/11/2017 N 0 15.00 NTERNAL MED 15. 01 Hospital-Based Health Clinic - RHC NCFIM - NORHTFIELD PARK 158525 99915 12/04/2017 0 O 15.01 Hospital-Based Health Clinic - FQHC 16.00 16, 00 Hospital-Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2019 12/31/2019 20.00 21.00 Type of Control (see instructions) 21.00 3. 00 1. 00 2. 00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for 22. 00 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. 22 01 Did this hospital receive interim uncompensated care payments for this 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 3 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.

	The fire cordinar 2, for discharges on or differ october 1. (see first detrois)				
		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance	N	N	N	45. 00
	with 42 CFR Section §412.320? (see instructions)				
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances	N	N	N	46. 00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through				
	Pt. III.				I
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47. 00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48. 00
	Teaching Hospitals				l
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes	N			56. 00
	or "N" for no.				
57. 00	If line 56 is yes, is this the first cost reporting period during which residents in approved				57. 00
	GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column				
	is "Y" did residents start training in the first month of this cost reporting period? Enter "Y	'			
	for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is				
	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				l
58. 00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as				58. 00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				
59. 00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59. 00

in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0030 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 5/18/2020 9:36 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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 Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for 76.00 no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

	Financial Systems HENRY COUNTY MEMORI AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	CN: 15-0030	In Lie Period: From 01/01/2019 To 12/31/2019	u of Form CMS- Worksheet S-2 Part I Date/Time Pre 5/18/2020 9:3	pared:
					1. 00	
	Long Term Care Hospital PPS					
80. 00 81. 00	Is this a long term care hospital (LTCH)? Enter "Y" for yes a ls this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			g period? Enter	N N	80. 00 81. 00
85. 00 86. 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 7 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
87. 00	Is this hospital an extended neoplastic disease care hospital	classified u	under section		N	87. 00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	XI X	
				1. 00	2. 00	
	Title V and XIX Services		. ""		.,,	
90. 00	Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? Er	iter "Y" for	N	Y	90.00
91. 00	Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applic			N	Y	91.00
92. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicabl	certi fi cati	on)? (see		N	92. 00
93. 00	Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.		XIX? Enter	N	N	93. 00
94. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, ar applicable column.	nd "N" for no	in the	N	N	94. 00
95. 00	If line 94 is "Y", enter the reduction percentage in the appli	cable column	١.	0. 00	0.00	95. 00
96. 00	Does title V or XIX reduce operating cost? Enter "Y" for yes capplicable column.	or "N" for no	in the	N	N	96. 00
97. 00 98. 00	If line 96 is "Y", enter the reduction percentage in the appli Does title V or XIX follow Medicare (title XVIII) for the inte stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.	erns and resi	dents post	0. 00 Y	0. 00 Y	97. 00 98. 00
98. 01	Does title V or XIX follow Medicare (title XVIII) for the repo C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for titl title XIX.	orting of cha le V, and in	arges on Wkst column 2 for	. Y	Y	98. 01
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calc bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.			Y	Y	98. 02
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.	cal access ho or "N" for r	ospital (CAH) no in column	1 N	N	98. 03
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH re outpatient services cost? Enter "Y" for yes or "N" for no in c in column 2 for title XIX.			N	N	98. 04
98. 05	Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col column 2 for title XIX.				Y	98. 05
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost re Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX. Rural Providers			Y	Y	98. 06
105 00	Does this hospital qualify as a CAH?			N		105. 00
	If this facility qualifies as a CAH, has it elected the all-ir for outpatient services? (see instructions)	nclusive meth	nod of paymen	•		106. 00
107. 00	If this facility qualifies as a CAH, is it eligible for cost r training programs? Enter "Y" for yes or "N" for no in column 1 yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2 reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see instr	ructions) If	t N		107. 00
108.00	N		108. 00			
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati ona	I Speech	Respi ratory	
		1. 00	2.00	3.00	4. 00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 00

for yes or "N" for no for each therapy.		
	1. 00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110. 00

are claimed, enter in column 2 the home office chain number. (see instructions)

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0030 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: To 12/31/2019 5/18/2020 9:36 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143. 00 Ci ty: 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 γ 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν N 148 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no N 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9. 99169. 00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy) 1.00 2.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 0171.00 N section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

	Financial Systems HENRY COUNTY MEM TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0030	In Lie Period: From 01/01/2019 To 12/31/2019		epared:
		<u> </u>	-	Y/N	Date	
	Consent Instruction. Fator V for all VFC responded. Fator N	l for all NO ra	onences Enter	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS	n for all no re	esponses. Ente	r air dates in	tne	
4 00	Provider Organization and Operation			T		1 00
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a	e beginning of column 2. (see	instructions)	N		1.00
	The special state of the state		Y/N	Date	V/I	
0.00	10		1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare I yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	mn 3, "V" for	N			2. 00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)					3.00
	Terationships: (See Thisti detrons)		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
4. 00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Cer-	tified Dublic	Y	A		4.00
4.00	Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date avaical unit as a column 3. (see instructions) If no, see instructions.		4.00			
5.00 Are the cost report total expenses and total revenues different from N						5. 00
	those on the filed financial statements? If yes, submit red	conciliation.		)/ /Al	1 1 0	
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities				21 00	
6.00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?		ne provider is			6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		during the	N N		7. 00 8. 00
9. 00	cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved		Ü	N		9. 00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		he current	N		10. 00
11. 00	cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00
	reaching riogram on worksheet A: IT yes, see mistractions.				Y/N	
	la				1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s see instruct	ions		Y	12. 00
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			st reporting	N N	13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement		-	tructions.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti				N N	15. 00
		Y/N	Tt A Date	Y/N	t B Date	
		1.00	2.00	3. 00	4. 00	
16. 00	PS&R Data  Was the cost report prepared using the PS&R Report only?  If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	02/28/2020	Y	02/28/2020	16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00

but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems HENRY COUNTY MEM	MORIAL HOSPITAL	_	In Lie	u of Form CM	S-2552-10								
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0030	Peri od: From 01/01/2019 To 12/31/2019		repared:								
			i pti on	Y/N	Y/N									
20.00	If Line 14 or 17 is was were adjustments made to DSOD		0	1. 00 N	3. 00 N	20. 00								
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN	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 records? If yes, see instructions.	N		N		21. 00								
					1. 00									
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	HOSPI TALS)		1.00									
	Capi tal Related Cost													
22. 00	Have assets been relifed for Medicare purposes? If yes, see		N	22. 00										
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	Ü	N	23. 00										
24. 00	Were new leases and/or amendments to existing leases entered of the leases and leases entered lf yes, see instructions	ed into during	this cost re	porting period?	N	24. 00								
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	If yes, see	N	25. 00								
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00								
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? If	yes, submit	N	27. 00								
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	ntered into dur	ing the cost	reporting	Υ	28. 00								
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	eserve Fund)	N	29. 00										
30. 00	treated as a funded depreciation account? If yes, see insti Has existing debt been replaced prior to its scheduled matu		debt? If ves	, see	N	30. 00								
31. 00	instructions. Has debt been recalled before scheduled maturity without is	•	•		N	31. 00								
31.00	instructions. Purchased Services	33uance of new	debt: 11 yes	, 300		31.00								
32. 00	Have changes or new agreements occurred in patient care ser		ed through co	ntractual	N	32. 00								
33. 00	arrangements with suppliers of services? If yes, see instructions 32 is yes, were the requirements of Sec. 2135.2 application, see instructions.		ng to competi	tive bidding? If	N	33. 00								
	Provi der-Based Physi ci ans													
34. 00	Are services furnished at the provider facility under an allf yes, see instructions.	rrangement with	n provi der-ba	sed physicians?	Y	34.00								
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the	provi der-based	N	35. 00								
				Y/N	Date									
	lu ossi o			1. 00	2. 00									
24 00	Home Office Costs			N		24 00								
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu	repared by the	home office?	N N		36. 00 37. 00								
38. 00	If yes, see instructions.					38. 00								
	the provider? If yes, enter in column 2 the fiscal year end	d of the home o	offi ce.											
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	•	,			39. 00								
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00								
		1.	00	2.	00									
	Cost Report Preparer Contact Information													
41. 00	held by the cost report preparer in columns 1, 2, and 3,	KYLE		SMI TH		41. 00								
42. 00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LL	_C			42. 00								
43. 00		317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43. 00								
	preport preparer in corumns rand 2, respectivery.	I		I	report preparer in columns 1 and 2, respectively.									

Heal th	Financial Systems HENRY COUNTY ME	MORI	IAL HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPI 7	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der CCN: 15-0030		riod: om 01/01/2019	Worksheet S-2 Part II		
				To			pared: 6 am	
			3. 00					
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	SEI	NIOR MANAGER				41.00	
	held by the cost report preparer in columns 1, 2, and 3,							
	respecti vel y.							
42.00	Enter the employer/company name of the cost report						42.00	
	preparer.							
43.00	Enter the telephone number and email address of the cost						43.00	
	report preparer in columns 1 and 2, respectively.							

| Period: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0030

					To	12/31/2019	Date/Time Prep 5/18/2020 9:30	
							I/P Days / 0/P	J alli
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2.00	3.00	4. 00	5. 00	
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							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			38	13, 870	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
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			48	17, 520	0. 00	0	14. 00
15. 00	CAH visits						0	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						_	21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )			_	_			23. 00
24. 00	HOSPI CE	116. 00		0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 01	RURAL HEALTH CLINIC II	88. 01					0	26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		4.0			0	26. 25
	Total (sum of lines 14-26)			48				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF			ا				31. 00
	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days							33. 00
	LTCH site neutral days and discharges							33. 00
55.01	Leton 31 to heatrai days and dischal ges			1	I.	l l		33.01

					5/18/2020 9:36 am			
		I/P Days	3 / O/P Visits	/ Trips	Full Time Equivalents			
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
		6.00	7. 00	8. 00	9. 00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 349	187	6, 168			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)	1, 772	1, 704				2. 00	
3.00	HMO IPF Subprovider	o	o				3. 00	
4.00	HMO IRF Subprovider	o	o				4. 00	
5.00	Hospital Adults & Peds. Swing Bed SNF	o	o	0			5. 00	
6.00	Hospital Adults & Peds. Swing Bed NF		ol	0			6.00	
7.00	Total Adults and Peds. (exclude observation	2, 349	187	6, 168			7. 00	
	beds) (see instructions)			•				
8.00	INTENSIVE CARE UNIT	626	o	1, 476			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	706			13. 00	
14. 00	Total (see instructions)	2, 975	187	8, 350		309. 48		
15. 00	CAH visits	0	0	0, 555			15. 00	
16. 00	SUBPROVI DER - I PF	-	٦				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	4, 622	120	10, 731	0.00	13. 66		
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	1, 522	.20	.0, .0.	0.00	.0.00	23. 00	
24. 00	HOSPI CE	0	o	0	0.00	5. 10		
24. 10	HOSPICE (non-distinct part)	Ĭ	Ĭ	44	0.00	00	24. 10	
25. 00	CMHC - CMHC						25. 00	
26. 00	RURAL HEALTH CLINIC	8, 070	3, 906	26, 972	0.00	53. 95		
26. 01	RURAL HEALTH CLINIC II	5, 556	16, 220	44, 979		74. 42	1	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0,000	0, 220	0	0.00			
27. 00	Total (sum of lines 14-26)	١	ĭ	O	0.00	456. 61		
28. 00	Observation Bed Days		195	1, 083	0.00	430.01	28. 00	
29. 00	Ambul ance Trips	0	173	1, 003			29.00	
30. 00	Employee discount days (see instruction)	٥		0			30.00	
31. 00	Employee discount days (see l'instruction)			0			31.00	
32. 00	Labor & delivery days (see instructions)	٥	4	38			32.00	
		۷	4	30 0				
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32. 01	
33. 00	LTCH non-covered days	0					33. 00	
	LTCH site neutral days and discharges	0					33. 00	
33.01	LIGHT SI LE HEULT AT LAYS AND UI SCHALLYES	ı Y	ı				J 33. UI	

 
 Heal th Financial
 Systems
 HENRY COUNTY MEMORIAL HOSPITAL

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CO
 In Lieu of Form CMS-2552-10 Provider CCN: 15-0030 

				''	0 12/31/2019	5/18/2020 9: 3	
		Full Time		Di sch	arges		
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and			0 845	47	2, 290	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)			463	432		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						,, ,,
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		0 845	47	2, 290	
15. 00	CAH visits	0.00		043	7,	2,270	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						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	0.00					23. 00
24. 00	HOSPI CE	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. 00	RURAL HEALTH CLINIC II	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00		0.00					20. 23
	Total (sum of lines 14-26)	0.00					28. 00
28. 00	Observation Bed Days						28.00
29. 00	Ambul ance Tri ps						
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
22.00	outpatient days (see instructions)			_			22.00
33. 00	LTCH non-covered days			0			33. 00
33.01	LTCH site neutral days and discharges			0			33. 01

	AL WAGE INDEX INFORMATION	IIL	INICI COUNTI WIEW	Provider CO	N: 15-0030 F	Peri od:	Worksheet S-3	
JI I 17	AL WAGE INDEX INTOKWATTOW			Trovider co	F	rom 01/01/2019 o 12/31/2019	Part II Date/Time Pre	pare
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	5/18/2020 9:30 Average Hourly	
		Number		on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col. 2 ± col.	Salaries in col. 4	col . 5)	
		1.00	2. 00	A-6) 3. 00	3) 4. 00	5. 00	6. 00	
	PART II - WAGE DATA							
00	SALARIES Total salaries (see	200. 00	44, 852, 155	-29, 586	44, 822, 569	1, 284, 537. 00	34. 89	1
	instructions)	200.00	11,002,100	27,000	11, 022, 007			'
00	Non-physician anesthetist Part		0	0	C	0.00	0. 00	2
00	A Non-physician anesthetist Part		0	o	C	0.00	0.00	) 3
0	B Dhysisian Bant A		15 000	0	15 000	100.00	02.22	,
00	Physician-Part A - Administrative		15, 000		15, 000	180.00	83. 33	3 4
01	Physicians - Part A - Teaching		0	o		0.00		
00	Physician and Non Physician-Part B		4, 489, 175	0	4, 489, 175	34, 262. 00	131. 02	2 5
00	Non-physician-Part B for		9, 423, 396	О	9, 423, 396	260, 814. 00	36. 13	8 6
	hospital-based RHC and FQHC services							
00	Interns & residents (in an	21. 00	0	o	C	0.00	0.00	7
01	approved program) Contracted interns and		0			0.00	0.00	) 7
<i>)</i>	residents (in an approved		U		C	0.00	0. 00	Ί΄
20	programs)						0.00	
00	Home office and/or related organization personnel		0	O O	C	0.00	0. 00	8
00	SNF	44. 00	0	0	C	0.00		
00	Excluded area salaries (see instructions)		3, 275, 352	209, 700	3, 485, 052	108, 493. 00	32. 12	2 10
	OTHER WAGES & RELATED COSTS							
00	Contract labor: Direct Patient Care		1, 134, 824	0	1, 134, 824	21, 183. 00	53. 57	11
00	Contract Labor: Top Level		0	О	C	0.00	0. 00	12
	management and other management and administrative							
	servi ces							
00	Contract Labor: Physician-Part A - Administrative		171, 846	0	171, 846	1, 421. 00	120. 93	1:
00	Home office and/or related		0	o	C	0.00	0. 00	14
	organization salaries and							
01	wage-related costs Home office salaries		0	o	C	0.00	0.00	14
02	Related organization salaries		0	o	C	0.00		
00	Home office: Physician Part A - Administrative		0	0	C	0.00	0. 00	1!
00	Home office and Contract		0	О	C	0.00	0. 00	10
	Physicians Part A - Teaching WAGE-RELATED COSTS							-
	Wage-related costs (core) (see		10, 807, 593	O	10, 807, 593	3		1:
00	instructions)							1,
00	Wage-related costs (other) (see instructions)							18
00	Excluded areas		622, 451	0	622, 451			19
00	Non-physician anesthetist Part A		0	٥	C	,		20
00	Non-physician anesthetist Part		0	o	C			2
00	B Physician Part A -		2, 864	0	2, 864			22
	Admi ni strati ve		_,	]	_,			
	Physician Part A - Teaching Physician Part B		635, 314	0	635, 314	)		22
	Wage-related costs (RHC/FQHC)		3, 002, 577		3, 002, 577			24
00	Interns & residents (in an		0	0	C	)		25
50	approved program) Home office wage-related		0	О	C			25
	(core)		-	_	_			
51	Related organization wage-related (core)		0		C			25
52	Home office: Physician Part A		0	o	C	)		25
	- Administrative - wage-related (core)							
	Home office & Contract		0	0	C			25
53	Dhugiaiana Dart A Tagahina							
53	Physicians Part A - Teaching -	l						
	wage-related (core)  OVERHEAD COSTS - DIRECT SALARIE	ES					29. 96	

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0030

Peri od: Worksheet S-3 From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared:

5/18/2020 9:36 am Wkst. A Line Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Number Reported on of Salaries Sal ari es Related to Wage (col. 4 col . 5) (from Wkst.  $(col.2 \pm col.$ Salaries in col. 4 A-6)3) 1.00 5.00 2.00 6.00 3.00 4.00 28.00 Administrative & General under 255, 685 255, 685 1, 173. 00 217. 98 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 29.00 0.00 Operation of Plant 30.00 7.00 1, 199, 908 1, 199, 908 45, 084. 00 26. 61 30.00 31.00 8.00 Laundry & Linen Service 0. 00 31.00 0.00 32.00 Housekeepi ng 9.00 520, 475 -21, 298 499, 177 38, 695. 00 12. 90 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 18. 13 14, 013. 00 34.00 10.00 834, 475 -580, 415 34.00 Di etary 254, 060 35.00 Di etary under contract (see 0.00 0.00 35.00 instructions) Cafeteri a 11.00 19, 092. 00 18. 13 36.00 346, 140 346, 140 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 38.00 Nursing Administration 13.00 2, 088, 668 25,000 2, 113, 668 52, 517. 00 40. 25 38.00 39.00 Central Services and Supply 14.00 468, 541 468, 541 16, 288. 00 28. 77 39.00 Pharmacy 0.00 40.00 15.00 0.00 40.00 Medical Records & Medical 41.00 16.00 682, 290 0 682, 290 31, 522. 00 21. 64 41.00 Records Library Social Service 0.00 42.00 42.00 17.00 0 0 0 0.00 0.00 43.00 43.00 Other General Service 18.00 0 0 0.00

HENRY COUNTY MEMORIAL HOSPITAL

Provider CCN: 15-0030
Period:
From 01/01/2019
To 12/31/2019
Part III
To 12/31/2019
Part III
Date/Time Prepared:
5/18/2020 9: 36 am

Worksheet A Amount Reclassificati Adjusted Paid Hours Average Hourly Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

			7	noon acon in oat.	, iaj ao coa		, o. agooa ,	i
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		31, 195, 269	-29, 586	31, 165, 683	990, 634. 00	31. 46	1. 00
	instructions)							l
2.00	Excluded area salaries (see		3, 275, 352	209, 700	3, 485, 052	108, 493. 00	32. 12	2. 00
	instructions)							l
3.00	Subtotal salaries (line 1		27, 919, 917	-239, 286	27, 680, 631	882, 141. 00	31. 38	3. 00
	minus line 2)							l
4.00	Subtotal other wages & related		1, 306, 670	0	1, 306, 670	22, 604. 00	57. 81	4. 00
	costs (see inst.)							l
5.00	Subtotal wage-related costs		10, 810, 457	0	10, 810, 457	0.00	39. 05	5. 00
	(see inst.)							l
6.00	Total (sum of lines 3 thru 5)		40, 037, 044	-239, 286	39, 797, 758	904, 745. 00	43. 99	6. 00
7.00	Total overhead cost (see		12, 129, 845	-230, 573	11, 899, 272	374, 105. 00	31. 81	7. 00
	instructions)							I

	To 12/31/2019	Date/Time Prep 5/18/2020 9:30	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Empl oyer Contributions	1, 869, 814	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Heal th 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)	9, 021, 506	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	118, 111	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	200, 707	11.00
12.00	, , ,	0	12.00
13.00		561, 910	13.00
14. 00	, , , , , , , , , , , , , , , , , , , ,	0	14.00
15. 00	'Workers' Compensation Insurance	283, 375	15. 00
16, 00	· ·	0	16.00
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	2, 980, 825	17.00
	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unempl oyment Insurance	14, 551	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22.00
	Tuition Reimbursement	20, 000	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15, 070, 799	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00
	· · · · · · · · · · · · · · · · · · ·	'	

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-1	10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0030	Peri od: Worksheet S-3 From 01/01/2019 Part V To 12/31/2019 Date/Common Prepared:	:

		To	0 12/31/2019	Date/Time Pre 5/18/2020 9:3	
	Cost Center Description		Contract Labor	Benefit Cost	
			1.00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1. 00	Total facility's contract labor and benefit cost		0	0	1. 00
2. 00	Hospi tal		0	0	2. 00
3. 00	Subprovi der - I PF				3. 00
4.00	Subprovi der - I RF				4. 00
5. 00	Subprovi der - (Other)		0	0	5. 00
6. 00	Swing Beds - SNF		0	0	6. 00
7. 00	Swing Beds - NF		0	0	7. 00
8. 00	Hospi tal -Based SNF				8. 00
9. 00	Hospi tal -Based NF				9. 00
	Hospi tal -Based OLTC				10. 00
	Hospi tal -Based HHA		0	0	11. 00
	Separately Certified ASC				12.00
	Hospi tal -Based Hospi ce		0	0	13.00
	Hospital-Based Health Clinic RHC		0	0	14. 00
	Hospital-Based Health Clinic RHC 1		0	0	14. 01
	Hospital-Based Health Clinic FQHC		0	0	15. 00
	Hospi tal -Based-CMHC				16. 00
	Renal Dialysis				17. 00
18. 00	Other		0	0	18. 00

	Financial Systems HE	ENRY COUNTY MEMO	ORIAL HOSPITAL Provider C	CN: 15-0030 I	Peri od:	eu of Form CMS-2 Worksheet S-4	
			Component		From 01/01/2019 To 12/31/2019		pared:
					Home Health	5/18/2020 9: 3 PPS	<u>6 am</u>
				<u> </u>	Agency I		
0.00	County				1.	00	0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	0		0 0	0	1. 00
2. 00	Unduplicated Census Count (see instructions)	0.00	259. 00	0. 00		0.00	
				Number of Emp	royees (ruii ii	ille Equi vai erit)	
					_		
		Enter the number your normal		Staff	Contract	Total	
		0	1	1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES  Administrator and Assistant Administrator(s)		40.00				3. 00
4.00	Director(s) and Assistant Director(s)		40.00	3. 9!	0.00	3. 95	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			1. 4 <sup>4</sup> 44. 50			1
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0. 00 25. 98			
9. 00	Physical Therapy Supervisor			0.00			1
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			2. 6° 0. 00			
12.00	Speech Pathology Service			0.08	0.00	0. 08	12. 00
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0.00			1
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15. 00
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			6. 1. 0. 00			1
18. 00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.00	0.00	0.00	18. 00
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				4		19. 00
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			17140			20. 00
20. 01	contains the first code).			26900			20. 01
20. 02 20. 03		_		34620 99915			20. 02 20. 03
		Full Ep Without		LUPA Episodes	PEP Only	Total (cols.	
		Outliers 1.00	2. 00	3.00	Epi sodes 4. 00	1-4) 5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	1, 727	183		1 2	1, 974	21. 00
22. 00	Skilled Nursing Visit Charges	543, 226	57, 099	19, 28	3 969	620, 577	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	2, 096 675, 343	32 10, 336	1		2, 150 692, 785	
25. 00	Occupational Therapy Visits	142	11		0	153	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	44, 227 34	3, 487 5	l .	0 0	47, 714 39	
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	10, 639	1, 454 0	1	0 0	12, 093 0	1
30.00	Medical Social Service Visit Charges	0	0		0	0	30. 00
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	290 43, 912	16 2, 432	1		306 46, 344	1
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4, 289	247	7!	5 11	4, 622	33. 00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1, 317, 347	74, 808	23, 80			35. 00
36. 00	Total Number of Episodes (standard/non outlier)	273		2:	3 1	297	36. 00
	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	3, 217	8 432		0 5		37. 00 38. 00

11000	Financial Systems HE	NRY COUNTY MEM	ORIAL HOSPITAL	-	In Lie	eu of Form CMS	-2552-1
HUSPI T	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0030	Peri od:	Worksheet S-	8
			Component	CCN: 15-8520	From 01/01/2019 To 12/31/2019		
					RHC I	Cost	
	Cl:::: Add   Id-::: 6:				1.	00	
1. 00	Clinic Address and Identification Street				2200 FOREST RI	DCE DADKWAY	1.00
1.00	Street		Ci	ty	State	ZIP Code	1.0
				00	2.00	3. 00	
2.00	City, State, ZIP Code, County		NEW CASTLE		IN	47362	2. 0
						1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	l or "II" for i	ırhan		1. 00	0 3.0
0.00	THOSE TIME BROED FRIEDS ONET. BOST GRACE OF LETT.	or it for full	1 01 0 101 0		nt Award	Date	0.0.
					1. 00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4. 0
5. 00 6. 00	Migrant Health Center (Section 329(d), PHS Ad Health Services for the Homeless (Section 340						5. 00 6. 00
6. 00 7. 00	Appalachian Regional Commission	Mu), FIIS ACL)					7. 0
8.00	Look-Alikes						8. 0
9. 00	OTHER (SPECIFY)						9. 0
10.00	D this fility	: +-1   b  D	UC FOUCO F		1.00	2. 00	0 10.0
10. 00	Does this facility operate as other than a hoyes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	ther operation	ns in column	N		0 10.0
	1.1.2.	Sun	day	N	londay	Tuesday	
		from	to	from	to	from	
	5 111 (1)	1. 00	2. 00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1)			08: 00	17: 00	08: 00	11.0
11.00	OET WILD			100.00	17.00	00.00	11.0
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. In numbers below.	d in CMS Pub. 1 umn 1. If yes,	00-04, chapter enter in colum	9, section nn 2 the	N N		12. 00 13. 00
	Tramber 3 berow.			Provi	ider name	CCN number	
					1.00	CCN number 2.00	
14. 00	RHC/FQHC name, CCN number				1.00	2. 00	14. 0
14. 00		Y/N 1.00	V 2.00	XVIII	1. 00 XI X	2.00 Total Visits	
	RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	Y/N 1.00	V 2. 00		1.00	2. 00	
	RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and		2.00	XVIII 3.00	1. 00 XI X	2.00 Total Visits	
	RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.		2. 00 Cou	XVIII 3.00	1. 00 XI X	2.00 Total Visits	
15. 00	RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2. 00 Cou	XVIII 3.00	1. 00 XI X	2.00 Total Visits	15.00
15. 00	RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	2. 00 Cou 4. HENRY	XVIII 3.00	1.00 XIX 4.00	2.00 Total Visits 5.00	
15. 00	RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2. 00 Cou 4. HENRY	XVIII 3.00	1.00 XIX 4.00	2.00 Total Visits	15.00
14. 00 15. 00 2. 00	RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00 Tuesday	2.00  Cou 4.  HENRY  Wedn	XVIII 3.00  anty 00  esday	1.00 XIX 4.00	2.00 Total Visits 5.00	15.00

Health Financial Systems HE	ENRY COUNTY MEMO	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 01/01/2019		
		Component	CCN: 15-8520	To 12/31/2019	Date/Time Pre	pared:
		·			5/18/2020 9:3	6 am
				RHC I	Cost	
	Frid	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

40.5PT I	<u> </u>	NRY COUNTY MEMO				eu of Form CMS- Worksheet S-8	
	TAL-BASED RHC/FQHC STATISTICAL DATA			CCN: 15-0030 CCN: 15-8525	Peri od: From 01/01/2019 To 12/31/2019		pared:
					RHC II	Cost	o alli
	Clinic Address and Identification				1.	00	
. 00	Street				152 WI TTENBRAK	ER AVE	1.0
				i ty	State	ZIP Code	
	City Chata 71D Cada Causty			. 00	2. 00	3.00	1 2 0
. 00	City, State, ZIP Code, County		NEW CASTLE		I N	47362	2.0
						1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	l or "U" for			0	3.0
					nt Award 1.00	Date 2.00	
	Source of Federal Funds			1	1.00	2.00	
1.00	Community Health Center (Section 330(d), PHS						4.0
. 00	Migrant Health Center (Section 329(d), PHS Ad						5.0
. 00	Health Services for the Homeless (Section 340 Appalachian Regional Commission	J(d), PHS ACT)					6. C
3. 00	Look-Alikes						8.0
00	OTHER (SPECIFY)						9. 0
					1. 00	2.00	
0. 00	Does this facility operate as other than a ho	spi tal -based R	HC or FQHC? E	nter "Y" for	N N		10.0
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)						
		Sund	day	N	Monday	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	CLINIC			08: 00	19: 00	08: 00	11.0
					1.00	2.00	
2. 00	Have you received an approval for an exception	on to the produc	ctivity stand	ard?	1. 00 N	2.00	12.0
	1		00-04, chapte	r 9, section	N	0	13. 0
3. 00	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report.						
3. 00	30.8? Enter "Y" for yes or "N" for no in colu			ders and	ider name	CCN number	1010
3. 00	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report.			ders and Provi	ider name 1.00	CCN number	
	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report.	List the names	of all provi	ders and Provi	1.00	2. 00	
	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.	List the names	of all provi	ders and Provi	1. 00 XI X	2.00 Total Visits	
4. 00	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.	List the names	of all provi	ders and Provi	1.00	2. 00	14.0
4. 00	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	List the names	of all provi	ders and Provi	1. 00 XI X	2.00 Total Visits	14. 0
4. 00	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	List the names	of all provi	ders and Provi	1. 00 XI X	2.00 Total Visits	14. 0
4. 00	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	List the names	of all provi	ders and Provi	1. 00 XI X	2.00 Total Visits	14.0
4. 00	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	List the names	of all provi	ders and Provi	1. 00 XI X	2.00 Total Visits	14.0
4. 00	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	List the names	of all provi	ders and Provi	1. 00 XI X	2.00 Total Visits	14.0
4. 00	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	List the names	V 2.00	ders and Provi	1. 00 XI X	2.00 Total Visits	14.0
5. 00	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00	V 2.00	Provi	1. 00 XI X	2.00 Total Visits	14. 0
5. 00	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Y/N 1.00	V 2.00	Provi	1.00 XIX 4.00	2.00 Total Visits 5.00	14. 0
	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00  Tuesday	V 2.00  Co 4 HENRY Wedr	XVIII 3.00  unty .00	1.00 XIX 4.00 Thur	2.00  Total Visits 5.00	14. 0
14. 00	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00	V 2.00	Provi	1.00 XIX 4.00	2.00 Total Visits 5.00	14. 0

Health Financial Systems	HENRY COUNTY MEM	MORIAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od: From 01/01/2019	Worksheet S-8	
		Component		To 12/31/2019		
				RHC II	Cost	
	Fri	day	Sa <sup>-</sup>	turday		
	from	to	from	to		
	11. 00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00	08: 00	19: 00		11. 00

Heal th	Financial Systems	HE	ENRY COUNTY MEN	MORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	AL-BASED HOSPICE IDENTIFICATION			Provi der C		Period: From 01/01/2019	Worksheet S-9	
				Hospi ce CCI	N: 15-1564	To 12/31/2019		pared:
-						Hospi ce I		
		Unduplicated		<u> </u>		<u> </u>		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1. 00	2.00	3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	ST REPORTING F	PERIODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4. 00
5.00	Total Hospice Days Part II - CENSUS DATA FOR COST	DEDODTI NO DEDI	ODC DECLAIMING	DEFODE OCTOBED	1 2015			5. 00
6. 00	Number of patients receiving	REPURITING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015 T			6.00
6.00	hospice care							0.00
7.00	Total number of unduplicated							7. 00
7.00	Continuous Care hours billable							7.00
	to Medicare							
8.00	Average Length of Stay (line 5							8. 00
	/ line 6)							
9.00	Unduplicated census count							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1. 00	2.00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	PERIODS BEGIN	NING ON OR AFT	ER OCTOBER 1			
10. 00	Hospice Continuous Home Care			0	1	0	1	1
11. 00	Hospice Routine Home Care			3, 167	1	36 930		11.00
12. 00	Hospice Inpatient Respite Care			21	1	0	-	1
13.00				14	1	2 (	16	
14. 00		L DATA FOR OO	T DEDODTING DE	3, 202		38 934		14. 00
15 00	PART IV - CONTRACTED STATISTICA	AL DATA FOR COS	ST KEPUKTING PE					15.00
15.00	The second secon			21		0 0		
16.00	Hospice General Inpatient Care			14	1	2 0	וי וי	16. 00

Health Financial Systems  HENRY COUNTY MEMORIAL HOSPITAL  Provider CCN: 15-0030  Period: From 01/01/2019 To 12/31/2019  Period: From 01/01/2019 To 12/31/2019  Date/Time 5/18/2020  Uncompensated and indigent care cost computation  1.00  Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  0.306  Medicaid (see instructions for each line)  2.00  Net revenue from Medicaid 3.00  Did you receive DSH or supplemental payments from Medicaid? 4.683, 4  4.683, 6  5.00  If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? 5.00  If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	S-10 Prepared: 9:36 am
Uncompensated and indigent care cost computation  Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  Medicaid (see instructions for each line)  Net revenue from Medicaid  3.00 Did you receive DSH or supplemental payments from Medicaid?  4.683, 4  4.683, 4  4.683, 6	9: 36 am
S/18/2020   Uncompensated and indigent care cost computation	9: 36 am
Uncompensated and indigent care cost computation  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  Medicaid (see instructions for each line)  2.00 Net revenue from Medicaid  3.00 Did you receive DSH or supplemental payments from Medicaid?  4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	516 1.00
1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  0.306  Medicaid (see instructions for each line)  2.00 Net revenue from Medicaid  3.00 Did you receive DSH or supplemental payments from Medicaid?  4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	516 1. OC
Medicaid (see instructions for each line)  2.00 Net revenue from Medicaid 4,683,7  3.00 Did you receive DSH or supplemental payments from Medicaid?  4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	616 1.00
2.00 Net revenue from Medicaid 3.00 Did you receive DSH or supplemental payments from Medicaid? 4,683,0 4,683,	
3.00 Did you receive DSH or supplemental payments from Medicaid? 4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	
4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	684 2. 00 3. 00
	4.00
o, oo iii iine a io no, then enter pon and/or supprementar payments 110m medicala	0 5.00
6.00 Medical d charges 34,447,	511 6.00
7.00 Medicaid cost (line 1 times line 6) 10,562,	158 7. OC
8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 5,878,	474 8.00
<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for each line)</pre>	
9.00 Net revenue from stand-alone CHIP	0 9.00
10. 00   Stand-al one CHIP charges	0 10.00
11.00 Stand-alone CHIP cost (line 1 times line 10)	0 11.00
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)	12.00
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or	0 13.00
10)	0 14.00
15.00 State or local indigent care program cost (line 1 times line 14)	0 15.00
16.00 Difference between net revenue and costs for state or local indigent care program (line 15 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 programs (see instructions for each line)	
17.00 Private grants, donations, or endowment income restricted to funding charity care	0 17.00
18.00 Government grants, appropriations or transfers for support of hospital operations	0 18.00
19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 5,878, 878, 12 and 16)	474 19.00
Uninsured Insured Total (col.	
patients patients + col. 2)	
Uncompensated Care (see instructions for each line)	
	472 20.00
(see instructions)	
	919 21.00
instructions)	0 00 00
22.00 Payments received from patients for amounts previously written off as 0 0 charity care	0 22.00
	919 23.00
1.00	24.00
24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit N imposed on patients covered by Medicaid or other indigent care program?	24.00
Thiposed on patrents covered by wedicard or other murgent care program:	0 25.00
25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of	1
25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	343 26 00
25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 9,598,	943 26.00 162 27.00
25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	162 27.00
25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit  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)  27.01 Medicare allowable bad debts for the entire hospital complex (see instructions)  346,  28.00 Non-Medicare bad debt expense (see instructions)  9,252,1	162 27. 00 402 27. 01 541 28. 00
25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit  26.00 Total bad debt expense for the entire hospital complex (see instructions)  27.01 Medicare reimbursable bad debts for the entire hospital complex (see instructions)  27.01 Medicare allowable bad debts for the entire hospital complex (see instructions)  28.00 Non-Medicare bad debt expense (see instructions)  29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)  2.958,1	162 27.00 402 27.01 541 28.00 217 29.00
25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit  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)  27.01 Medicare allowable bad debts for the entire hospital complex (see instructions)  28.00 Non-Medicare bad debt expense (see instructions)  29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)  20.00 Cost of uncompensated care (line 23 column 3 plus line 29)  3.874,	162 27. 00 402 27. 01 541 28. 00

Health Financial Systems	HENRY COUNTY MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der C	CN: 15-0030	Peri od:	Worksheet A	
				From 01/01/2019 Fo 12/31/2019	Date/Time Pre	nared·
				12/31/201/	5/18/2020 9: 3	
Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	2. 00	3. 00	4. 00	col . 4) 5.00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT		5, 857, 955	5, 857, 95	-92, 352	5, 765, 603	1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		0		459, 446	459, 446	1
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	270, 812	10, 941, 665			13, 218, 975	
5. 00   00500   ADMINISTRATIVE & GENERAL	5, 808, 991	10, 232, 965			16, 039, 841	1
7. 00   00700   OPERATION OF PLANT	1, 199, 908	1, 653, 163		1	2, 853, 071	1
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG	0 520, 475	405, 580 343, 633		1	405, 580 828, 748	1
10. 00   01000 DI ETARY	834, 475	617, 877			442, 176	1
11. 00 01100 CAFETERI A	0	0		602, 435	602, 435	
13.00 01300 NURSING ADMINISTRATION	2, 088, 668	219, 095	2, 307, 76			1
14.00 01400 CENTRAL SERVICES & SUPPLY	468, 541	405, 276	873, 81		873, 817	14. 00
15. 00   01500   PHARMACY	0	4, 686, 338			4, 394, 116	•
16. 00 01600 MEDI CAL RECORDS & LI BRARY	682, 290	154, 976	837, 26	6 -419	836, 847	16. 00
I NPATIENT ROUTINE SERVICE COST CENTERS  30. 00 03000 ADULTS & PEDIATRICS	5, 674, 995	1, 409, 026	7, 084, 02	-838, 412	6, 245, 609	30.00
31. 00   03100   NTENSI VE CARE UNI T	1, 220, 496	268, 604			1, 488, 200	•
43. 00 04300 NURSERY	0	0		639, 565	639, 565	
ANCILLARY SERVICE COST CENTERS						]
50. 00   05000   OPERATING ROOM	4, 340, 735	9, 038, 953			5, 803, 042	
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	0		164, 873	164, 873	
54. 00   05400   RADI OLOGY-DI AGNOSTI C 57. 00   05700   CT   SCAN	1, 591, 679	909, 366			2, 227, 664	1
57.00   05700   CT SCAN 58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)	178, 876 106, 917	920, 548 481, 880			1, 099, 424 588, 797	
59. 00   05900   CARDI AC CATHETERI ZATI ON	100, 917	401, 660			0 388, 747	1
60. 00   06000   LABORATORY	1, 929, 328	2, 288, 178		- 1	4, 217, 506	1
60. 01   06001   BL00D   LABORATORY	0	0		0	0	
65. 00 06500 RESPI RATORY THERAPY	624, 926	196, 718			816, 545	1
66. 00   06600   PHYSI CAL THERAPY	1, 511, 352	997, 487		1	2, 508, 324	1
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	203, 150	14, 822			217, 972	
68. 00   06800  SPEECH PATHOLOGY 69. 00   06900  ELECTROCARDI OLOGY	86, 959 182, 664	6, 093 173, 135		1	93, 052 355, 799	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	102,004	-302, 423		1	1, 536, 278	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	o	0	332, 12	5, 439, 211	5, 439, 211	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
76. 00 03950 CARDI AC REHAB	119, 437	20, 749	140, 18	6 0	140, 186	76. 00
OUTPATIENT SERVICE COST CENTERS	0 (44 000	4 740 000	T 5 054 00		4 (54 040	00.00
88. 00   08800   RURAL HEALTH CLINIC 88. 01   08801   RURAL HEALTH CLINIC II	3, 614, 020 5, 827, 503	1, 740, 309 3, 207, 903			4, 654, 949 8, 307, 833	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	3, 027, 303	3, 207, 303	7, 033, 40	0 -727, 373	0, 307, 033	1
91. 00   09100   EMERGENCY	2, 489, 606	1, 000, 005	3, 489, 61	1 0	3, 489, 611	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	1 070 (04	057 (00	1 400 05	10.000		
101. 00 10100 HOME HEALTH AGENCY  SPECIAL PURPOSE COST CENTERS	1, 072, 631	357, 622	1, 430, 25	-12, 023	1, 418, 230	1101.00
113. 00 11300 I NTEREST EXPENSE		0		0	0	113. 00
114.00 11400 UTILIZATION REVIEW-SNF	O	0		o o		114. 00
116. 00 11600 H0SPI CE	422, 222	349, 345	771, 56 <sup>-</sup>	7 -4, 770		
118.00 SUBTOTALS (SUM OF LINES 1 through 117	7) 43, 071, 656	58, 596, 843	101, 668, 49	-395, 614	101, 272, 885	118. 00
NONREI MBURSABLE COST CENTERS				اما		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 109, 599	664, 108	1, 773, 70	7 -71, 755		190.00
194. 00 07950 HOSPI TALI ST	1, 109, 399	004, 100	1,773,70	) -71, 735		194. 00
194. 01 07951 RENTAL	Ö	0		92, 352		194. 01
194.05 07955 OTHER NONREIMBURSABLE COSTS	0	169, 011	169, 01	1 0	169, 011	194. 05
194. 06 07956 DR AFZAL	0	8, 681				194. 06
194. 07 07957 PHI LLI PS HALL	0	0	1	0		194. 07
194.08 07958 0B DRS 194.09 07959 THE WATERS	0	0		0 0 443, 101	443, 101	194. 08
194. 10 07960 CAMBRI DGE CITY	434, 615	255, 558	690, 17		634, 076	
194. 11 07961 WELL BEING	70, 401	39, 774			100, 006	
194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC	0	66, 122				194. 12
194.13 07963 NEW CASTLE PEDIATRICS	0	0		o  o	0	194. 13
194. 14 07964 HENRY COUNTY RADI OLOGY	165, 884	1, 555, 995	1, 721, 87	-1, 818		
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY	0	0	1			194. 15 194. 16
194.16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY 200.00  TOTAL (SUM OF LINES 118 through 199)	0 44, 852, 155	61, 356, 092	106, 208, 24	7 0	106, 208, 247	
1.2.1.2 (22 5) E.H.E5 1.15 (1 50g) 1777	, 552, . 50	2., 300, 372	1	٦		,

Provi der CCN: 15-0030

Period: Worksheet A From 01/01/2019 To 12/31/2019 Date/Time Prepared: 5/18/2020 9:36 am

			5/18/2020 9:3	36 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7.00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	-137, 542	5, 628, 061		1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	0			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 878, 057			4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-2, 812, 252			5. 00
7. 00 00700 OPERATION OF PLANT	0			7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE	Ö			8. 00
9. 00   00900   HOUSEKEEPI NG	0			9. 00
10. 00   01000 DI ETARY	-24, 181			10.00
11. 00   01100   CAFETERI A				11.00
	-418, 154			
13. 00 01300 NURSI NG ADMI NI STRATI ON	90, 721			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0			14. 00
15. 00   01500   PHARMACY	-977, 282		l control of the cont	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	-5, 700	831, 147		16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00  03000 ADULTS & PEDIATRICS	-2, 166, 516	4, 079, 093	3	30. 00
31.00  03100 INTENSIVE CARE UNIT	0	1, 488, 200		31.00
43. 00 04300 NURSERY	0	639, 565		43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	-2, 583, 646	3, 219, 396		50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	164, 873	3	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-1, 605	2, 226, 059		54.00
57. 00 05700 CT SCAN	-619, 692			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	-295, 228	l ·		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		l e e e e e e e e e e e e e e e e e e e	59. 00
60. 00   06000   LABORATORY	-29, 362	_		60.00
60. 01 06001 BLOOD LABORATORY	27,302	l		60.01
65. 00 06500 RESPI RATORY THERAPY	-27, 588	_		65. 00
66. 00   06600 PHYSI CAL THERAPY				•
	-818, 003			66.00
	-30			67. 00
68. 00 06800 SPEECH PATHOLOGY	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0			69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	,		71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	5, 439, 211		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
76. 00 03950 CARDI AC REHAB	0	140, 186		76. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	-419, 803	4, 235, 146		88. 00
88.01   08801   RURAL HEALTH CLINIC II	-1, 910, 839	6, 396, 994		88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
91. 00   09100   EMERGENCY	-16, 318	3, 473, 293	3	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY	-15, 142	1, 403, 088	3	101. 00
SPECIAL PURPOSE COST CENTERS			1	
113. 00 11300   NTEREST EXPENSE	0	0		113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0		l e e e e e e e e e e e e e e e e e e e	114.00
116. 00 11600 H0SPI CE	-14, 555			116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-10, 324, 660	l ·		118. 00
NONREI MBURSABLE COST CENTERS	10, 324, 000	70, 740, 223	<u>'</u>	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0			192. 00
194. 00 07950 HOSPI TALI ST				194. 00
194. 01 07951 RENTAL	0	,		194. 01
194. 05 07955 OTHER NONREI MBURSABLE COSTS	0			194. 05
194. 06 07956 DR AFZAL	0	-,		194. 06
194. 07 07957 PHI LLI PS HALL	0			194. 07
194. 08 07958 OB DRS	0	_	)	194. 08
194. 09 07959 THE WATERS	0	443, 101	l e e e e e e e e e e e e e e e e e e e	194. 09
194. 10 07960 CAMBRI DGE CITY	0	634, 076		194. 10
194. 11 07961 WELL BEING	0	100, 006		194. 11
194.12 07962 ACTIVATE HEALTH EMPLOYER CLINIC	0	66, 122	2	194. 12
194. 13 07963 NEW CASTLE PEDIATRICS	0	0		194. 13
194. 14 07964 HENRY COUNTY RADI OLOGY	0	1, 720, 061		194. 14
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY	0			194. 15
194.16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	0		194. 16
200.00 TOTAL (SUM OF LINES 118 through 199)	-10, 324, 660	95, 883, 587	,	200. 00
	•	•	•	

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

RECLASSIFICATIONS Provider CCN: 15-0030 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

						o 12/31/2019	Date/Time Prepared: 5/18/2020 9:36 am
		Increases					07 107 2020 7. 00 um
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	A - OB/NURSERY/L&D	40.00	554 000	00 (77			
1.00	NURSERY	43.00	556, 888	82, 677			1.00
2. 00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	14 <u>3, 5</u> 60 700, 448	2 <u>1, 3</u> 13 103, 990			2. 00
	B - CAFETERIA		700, 440	103, 770			
1.00	CAFETERI A	11. 00	346, 140	256, 295			1.00
	0 — — — — —		346, 140	256, 295			
	C - WATERS EXCLUSIONS						
1.00	THE WATERS	194. 09	255, 573	187, 528			1. 00
2.00		0.00	0	0			2. 00
	D - DEPRECIATION POB		255, 573	187, 528			
1. 00	RENTAL	194. 01	0	92, 352			1. 00
	0			92, 352			
	E - EQUIPMENT RENTAL						
1.00	NEW CAP REL COSTS-MVBLE	2. 00	0	459, 446			1. 00
2 00	EQUI P	0.00					2 00
2. 00 3. 00		0. 00 0. 00	0	0			2. 00 3. 00
4. 00		0.00	0	0			4. 00
5. 00		0.00	ő	o			5. 00
6.00		0.00	o	0			6. 00
7.00		0.00	0	0			7. 00
	0		0	459, 446			
1. 00	F - IMPLANTABLE DEVICES IMPL. DEV. CHARGED TO	72.00		F 420 211			1.00
1.00	PATIENT	72.00		5, 439, 211			1. 00
	0			5, 439, 211			
	H - VERO		<u>'</u>				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	29, 586			1. 00
2.00		0.00	•	0			2. 00
	TOTALS  I - MEDICAL DIRECTOR RECLASS		0	29, 586			
1. 00	NURSI NG ADMI NI STRATI ON	13.00	25, 000	0			1.00
1.00	0		25, 000	0			1.00
	L - MED SUPPLIES RECLASS		20,000	<u> </u>			
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	7, 277, 912			1. 00
	PATI ENTS		+				
	0 LODECT DIDCE CTAFE DECLACE		0	7, 277, 912			
1. 00	M - FOREST RIDGE STAFF RECLASS	88.00	15, 146	0			1. 00
2. 00	RURAL HEALTH CLINIC II	88. 01	97, 848				2. 00
	0		112, 994	0			
	N - NORTHFIELD STAFF RECLASS						
1.00	RURAL HEALTH CLINIC II	<u>88.</u> 01	<u>5, 7</u> 27	0			1. 00
	O DENEEL E DEGLACO		5, 727	0			
1. 00	O - BENEFIT RECLASS EMPLOYEE BENEFITS DEPARTMENT	4. 00	ol	1, 976, 912			1. 00
2. 00	LWIFLOTEL BENEFITS DEFARTMENT	0.00	0	1, 970, 912			2.00
3. 00		0.00	Ö	Ö			3. 00
4.00		0.00	o	0			4. 00
5.00		0.00	O	0			5. 00
6.00		0.00	0	0			6. 00
7.00		0.00	0	0			7. 00
8. 00 9. 00		0. 00 0. 00	0	0			8. 00 9. 00
9. 00 10. 00		0.00	O	0			10. 00
11. 00		0.00	ol	0			11. 00
12. 00		0.00	o	Ö			12. 00
	0			1, 976, 912			
500.00	Grand Total: Increases		1, 445, 882	15, 823, 232			500. 00

| Period: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0030

Cost Center   Line #   Sal ary   Other   West, A-7 Ref							To 12/31/2019	Date/Time Prepared: 5/18/2020 9:36 am
Color   Colo			Decreases					7. 107 2020 7. 30 am
A - OR/BURSERY/LIND 1.00   ADDRESS   DEDITIFIES   SO 0.00   TOO, 448   TOO, 500   DO 0   C. 2.00		Cost Center		Sal ary				
1.00			7. 00	8. 00	9. 00	10. 00		
1.00   0			20.00	700 440	100 000	1	,	4.00
1.00   B   CAFLERIA   10.00   346, 140   256, 295   0   0   1.00   0   346, 140   256, 295   0   0   1.00   0   0   346, 140   256, 295   0   0   1.00   0   0   0   0   0   0   0   0   0		ADULIS & PEDIATRICS	•					•
B - CAFETERIA	2.00				:		<u>/</u>	2.00
1.00		B = CΔFFTERIΔ		700, 446	103, 770			
0	1.00		10.00	346, 140	256, 295	(		1.00
C. WATERS EXCLUSIONS		0	<u> </u>				<u> </u>	
2.00   DIETARY   10.00   234,275   173,466   0   2.00   D DEPRECIATION POB   1.00   255,573   187,578		C - WATERS EXCLUSIONS		9.157.1.5	=======================================	II.		
1.00   DEPRECIATION POB   1.00   0   92,352   9   1.00	1.00	HOUSEKEEPI NG	9. 00	21, 298	14, 062	(		1. 00
1.00   New Cap Fell COSTS - BLD &   1.00   0   92, 352   9   1.00	2.00	DI ETARY	10.00	234, 275	173, 466	(		2. 00
1.00		0		255, 573	187, 528			
FLXT						1		
0	1.00		1. 00	0	92, 352	Ġ	9	1. 00
Color   Colo		FIXT — — — — —			— — . <del></del>			
1.00		0		0	92, 352			
2. 00   MEDI CAL RECORDS & LIBRARY   16. 00   0   419   0   3. 00	1 00		15.00	ما	00 011	1	J	1 00
3.00   INTENSIVE CARE UNIT   31.00   0 900   0   3.00   4.00   ORADIOLOGY-DIAGNOSTIC   54.00   0   273.881   0   5.00   6.00   RADIOLOGY-DIAGNOSTIC   54.00   0   273.881   0   6.00   7.00   PHYSICAL THERAPY   65.00   0   515   0   7.00   PHYSICAL THERAPY   65.00   0   515   0   7.00   PHYSICAL THERAPY   66.00   0   515   0   7.00   PHYSICAL THERAPY   66.00   0   515   0   7.00   PHYSICAL THERAPY   66.00   0   51.00   7.00   PHYSICAL SUPPLIES CHARGED TO   71.00   0   5.439.211   0   7.00   PATIENTS   70.00   70.439.211   0   70.00   70.00   7.00   PESPIRATIORY THERAPY   65.00   4.530   0   0   0   0   7.00   PHYSICAL DIRECTOR RECLASS   70.00   70.00   70.00   70.00   7.00   PHYSICAL DIRECTOR RECLASS   70.00   70.00   70.00   70.00   70.00   7.00   PHYSICAL DIRECTOR RECLASS   70.00   70.			•	-			1	•
4. 00 OPERATING ROOM 50. 00 0 84,857 0 5. 00 4. 00 5. 00 86. 00 7. 00 RESPIRATORY THERAPY 65. 00 0 273,381 0 5. 00 6. 00 8 F.SPIRATORY THERAPY 65. 00 0 5.63 0 6. 00 7. 00 PHYSICIAL THERAPY 66. 00 0 5. 15. 5 0 7. 00 9 RESPIRATORY THERAPY 66. 00 0 5. 459,446 7. 00 9 REDICAL SUPPLIES CHARGED TO 71. 00 0 5. 439, 211 0 9 PATI ENTS 7 0 0 5. 439, 211 0 9 PATI ENTS 7 0 0 5. 439, 211 0 9 PATI ENTS 7 0 0 5. 439, 211 0 9 PATI ENTS 7 0 0 5. 439, 211 0 9 PATI ENTS 7 0 0 5. 439, 211 0 9 PATI ENTS 7 0 0 5. 439, 211 0 9 PATI ENTS 8 PEDI ATRICS 8 30. 00 25. 050 0 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0		•	•	0				•
5.00			•	0			)	•
6. 00 RESPIRATORY THERAPY 65. 00 0 563 0 7. 00 6. 00 7. 00 PHYSICAL THERAPY 66. 00 0 515 0 7. 00 PATIENTS 7. 00				0				
7.00		•	•	0				•
The implication of the implica		•	1	o				•
1.00   MEDICAL SUPPLIES CHARGED TO								
PATI ENTS		F - IMPLANTABLE DEVICES	<u> </u>	•				
O	1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	5, 439, 211	(		1. 00
H - VERO		PATI ENTS						
1.00   ADULTS & PEDIATRI CS   30.00   25,050   0   0   0   0   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00		0		0	5, 439, 211			
2.00   RESPIRATORY THERAPY   65.00   4,536   0   0   0   1   1   1   1   1   1   1			20.00	05 050		1	,	
TOTALS			1				1	•
- MEDICAL DIRECTOR RECLASS	2.00		65.00				<u> </u>	2.00
1.00				29, 300	0			
1.00     25,000   0	1 00		192 00	25 000	0		)	1 00
1.00   OPERATING ROOM   SO.00   OPERATING ROOM   SO.00   OPERATING ROOM	1.00	0			— — <u> </u>	<del>                                     </del>	2	1.00
1.00   OPERATING ROOM		L - MED SUPPLIES RECLASS		20,000			1	
1. 00   RURAL HEALTH CLINIC   88.00   97,848   0   0   0   0   0   0   0   0   0	1.00		50.00	0	7, 277, 912	(		1. 00
1.00   RURAL HEALTH CLINIC   88.00   97,848   0   0   0   0   2.00   0   0   0   0   0   0   0   0   0					7, 277, 912			
2.00   PHYSICIANS' PRIVATE OFFICES   192.00   15,146   0   0   0   0   0   0   0   0   0			S					
1.00   N - NORTHFIELD STAFF RECLASS   194.10   5,727   0   0   0   0   0   0   0   0   0			•		0		1	•
N - NORTHFIELD STAFF RECLASS   194. 10	2.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00		:		<u> </u>	2. 00
1.00 CAMBRI DGE CLTY 194.10 5,727 0 0 1.00		0		112, 994	0			
O         5,727         O           0 - BENEFIT RECLASS         1.00         ADMINISTRATIVE & GENERAL         5.00         0         2,115         0         1.00           2.00         PHARMACY         15.00         0         193,411         0         2.00           3.00         ADULTS & PEDIATRICS         30.00         0         8,924         0         3.00           4.00         OPERATING ROOM         50.00         0         213,877         0         4.00           5.00         RURAL HEALTH CLINIC         88.00         0         616,678         0         5.00           6.00         RURAL HEALTH AGENCY         101.00         0         831,148         0         6.00           7.00         HOME HEALTH AGENCY         101.00         0         12,023         0         7.00           8.00         HOSPICE         116.00         0         4,770         0         8.00           9.00         PHYSICIANS' PRIVATE OFFICES         192.00         0         31,609         0         9.00           10.00         CAMBRI DGE CI TY         194.10         0         50,370         0         10.00           11.00         HENRY COUNTY RADIOLOGY         194.	1 00		104 10	F 707		1	\[ \	1 00
O - BENEFIT RECLASS           1. 00 ADMINISTRATI VE & GENERAL         5. 00         0         2, 115         0         1. 00           2. 00 PHARMACY         15. 00         0         193, 411         0         2. 00           3. 00 ADULTS & PEDI ATRI CS         30. 00         0         8, 924         0         3. 00           4. 00 OPERATI NG ROOM         50. 00         0         213, 877         0         4. 00           5. 00 RURAL HEALTH CLI NI C         88. 00         0         616, 678         0         5. 00           6. 00 RURAL HEALTH AGENCY         101. 00         0         831, 148         0         6. 00           7. 00 HOME HEALTH AGENCY         101. 00         0         12, 023         0         7. 00           8. 00 HOSPI CE         116. 00         0         4, 770         0         8. 00           9. 00 PHYSI CI ANS' PRI VATE OFFI CES         192. 00         0         31, 609         0         9. 00           10. 00 CAMBRI DGE CI TY         194. 10         0         50, 370         0         10. 00           11. 00 HENRY COUNTY RADI OLOGY         194. 11         0         10, 169         0         11. 00           12. 00 HENRY COUNTY RADI OLOGY         194. 14	1.00	CAMBRIDGE CITY	194.10			<u> </u>	<u>)</u>	1.00
1.00 ADMINISTRATIVE & GENERAL 5.00 0 2, 115 0 1.00 2.00 ADMINISTRATIVE & GENERAL 5.00 0 193, 411 0 2.00 3.00 ADULTS & PEDIATRICS 30.00 0 8, 924 0 3.00 4.00 OPERATING ROOM 50.00 0 213, 877 0 4.00 5.00 RURAL HEALTH CLINIC 88.00 0 616, 678 0 5.00 RURAL HEALTH CLINIC 11 88.01 0 831, 148 0 5.00 F.00 F.00 HOME HEALTH AGENCY 101.00 0 12, 023 0 7.00 F.00 F.00 F.00 F.00 F.00 F.00 F.		O PENEELT DECLASS		5, 727	U			
2.00 PHARMACY 15.00 0 193, 411 0 2.00 3.00 ADULTS & PEDIATRICS 30.00 0 8, 924 0 3.00 4.00 OPERATING ROOM 50.00 0 213, 877 0 4.00 5.00 RURAL HEALTH CLINIC 88.00 0 616, 678 0 5.00 6.00 RURAL HEALTH CLINIC II 88.01 0 831, 148 0 6.00 7.00 HOME HEALTH AGENCY 101.00 0 12, 023 0 7.00 8.00 HOSPICE 116.00 0 4, 770 0 8.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 31, 609 0 9.00 PHYSICIANS' PRIVATE OFFICES 194.10 0 50, 370 0 10.00 CAMBRIDGE CITY 194.10 0 50, 370 0 10.00 WELL BEING 194.11 0 10, 169 0 12.00 HENRY COUNTY RADIOLOGY 194.14 0 1, 818 0 12.0	1 00		5.00	٥	2 115			1 00
3.00 ADULTS & PEDIATRICS 30.00 0 8, 924 0 4.00 OPERATING ROOM 50.00 0 213, 877 0 4.00 50.00 50.00 50.00 50.00 50.00 50.00 616, 678 0 5.00 6.00 RURAL HEALTH CLINIC II 88.01 0 831, 148 0 6.00 7.00 HOME HEALTH AGENCY 101.00 0 12, 023 0 7.00 8.00 HOSPICE 116.00 0 4, 770 0 8.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 31, 609 0 9.00 10.00 CAMBRIDGE CITY 194.10 0 50, 370 0 10.00 CAMBRIDGE CITY 194.11 0 10, 169 0 11.00 12.00 HENRY COUNTY RADIOLOGY 194.14 0 1, 818 0 12.00 0 1.976, 912			!					
4.00 OPERATING ROOM 50.00 0 213,877 0 4.00 5.00 RURAL HEALTH CLINIC 88.00 0 616,678 0 5.00 6.00 RURAL HEALTH CLINIC II 88.01 0 831,148 0 6.00 7.00 HOME HEALTH AGENCY 101.00 0 12,023 0 7.00 8.00 HOSPICE 116.00 0 4,770 0 8.00 9.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 31,609 0 9.00 10.00 CAMBRIDGE CITY 194.10 0 50,370 0 10.00 11.00 WELL BEING 194.11 0 10,169 0 11.00 12.00 HENRY COUNTY RADIOLOGY 194.14 0 1,976,912								•
5.00     RURAL HEALTH CLINIC     88.00     0     616,678     0       6.00     RURAL HEALTH CLINIC II     88.01     0     831,148     0       7.00     HOME HEALTH AGENCY     101.00     0     12,023     0     7.00       8.00     HOSPICE     116.00     0     4,770     0     8.00       9.00     PHYSI CLANS' PRI VATE OFFICES     192.00     0     31,609     0     9.00       10.00     CAMBRI DGE CLTY     194.10     0     50,370     0     10.00       11.00     WELL BELNG     194.11     0     10,169     0     11.00       12.00     HENRY COUNTY RADIOLOGY     194.14     0     1,818     0     0       0     1,976,912								•
6.00 RURAL HEALTH CLINIC II 88.01 0 831, 148 0 6.00 7.00 HOME HEALTH AGENCY 101.00 0 12, 023 0 7.00 8.00 HOSPICE 116.00 0 4, 770 0 8.00 9.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 31, 609 0 9.00 10.00 CAMBRIDGE CITY 194.10 0 50, 370 0 10.00 11.00 WELL BEING 194.11 0 10, 169 0 11.00 12.00 HENRY COUNTY RADIOLOGY 194.14 0 1, 818 0 12.00							1	- I
7. 00 HOME HEALTH AGENCY 101. 00 0 12, 023 0 7. 00 8. 00 HOSPI CE 116. 00 0 4, 770 0 8. 00 9. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 31, 609 0 9. 00 10. 00 CAMBRI DGE CI TY 194. 10 0 50, 370 0 10. 00 WELL BEI NG 194. 11 0 10, 169 0 11. 00 HENRY COUNTY RADI OLOGY 194. 14 0 1, 818 0 0 12. 00 0 1, 976, 912				O				- I
8.00 HOSPICE 116.00 0 4,770 0 8.00 9.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 31,609 0 9.00 10.00 CAMBRIDGE CITY 194.10 0 50,370 0 10.00 11.00 WELL BEING 194.11 0 10,169 0 11.00 12.00 HENRY COUNTY RADIOLOGY 194.14 0 1,976,912		•		o				
10. 00 CAMBRI DGE CI TY 194. 10 0 50, 370 0 10. 00 11. 00 WELL BEING 194. 11 0 10, 169 0 11. 00 12. 00 HENRY COUNTY RADI OLOGY 194. 14 0 12. 00 0 1, 818 0 12. 00	8.00	HOSPI CE	116.00	0				8. 00
11. 00 WELL BEING 194. 11 0 10, 169 0 11. 00 12. 00 HENRY COUNTY RADIOLOGY 194. 14 0 17, 818 0 12. 00	9.00	PHYSICIANS' PRIVATE OFFICES		o			)	9. 00
12. 00 HENRY COUNTY RADI OLOGY 194. 14 0 1,818 0 12. 00			•	O			)	•
0 1, 976, 912				0				
	12. 00	HENRY COUNTY RADIOLOGY	1 <u>94.</u> 14	•			<u>)</u>	12. 00
500. 00   brand lotal: Decreases     1,4/5,468   15,793,646     500. 00	F00 00	O Consideration D		-			1	500.00
	500.00	ы and rotal: Decreases	I	1, 4/5, 468	15, 793, 646	1	I	500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0030 Peri od: Worksheet A-7 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 5/18/2020 9:36 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 46,000 1.00 0 1.00 2, 081, 914 0 2.00 Land Improvements 13, 598 13, 598 0 2.00 ő 3.00 42, 241, 336 2, 261, 750 2, 261, 750 3 00 Buildings and Fixtures 1, 243, 352 0 4.00 Building Improvements 1, 115, 708 354, 873 354, 873 0 4.00 5.00 Fixed Equipment 17, 368, 753 659, 853 0 659, 853 2, 350, 941 5.00 0 669, 917 6.00 Movable Equipment 41, 109, 127 2, 796, 501 2, 796, 501 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 103, 962, 838 6, 086, 575 6, 086, 575 4, 264, 210 8.00 9.00 Reconciling Items 0 9.00 103, 962, 838 Total (line 8 minus line 9) 4, 264, 210 10.00 6, 086, 575 0 6,086,575 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 46,000 0 1.00 2.00 Land Improvements 2, 095, 512 0 2.00 3.00 Buildings and Fixtures 43, 259, 734 0 3.00 0 4.00 Building Improvements 1, 470, 581 4.00 5.00 Fi xed Equipment 15, 677, 665 0 5.00 Movable Equipment 6.00 43, 235, 711 0 6.00 7. 00 7.00 HIT designated Assets 0

105, 785, 203

105, 785, 203

0

0

Heal th	Financial Systems H	ENRY COUNTY MEM	ORIAL HOSPITAL	-	In Lie	u of Form CMS-:	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der C		Peri od:	Worksheet A-7	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	
						5/18/2020 9:3	<u>6 am</u>
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	5, 468, 329	0	389, 62	6 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	)	0 0	0	2.00
3.00	Total (sum of lines 1-2)	5, 468, 329	0	389, 62	6 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	n			
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				

1. 00 2. 00 3. 00

Heal th	n Financial Systems H	ENRY COUNTY MEN	MORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	F	Period: From 01/01/2019 To 12/31/2019		
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
	T	1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		1	1	2 400470		
1.00	NEW CAP REL COSTS-BLDG & FIXT	44, 850, 428	l .	44, 850, 428			1.00
2. 00 3. 00	NEW CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	59, 532, 356 104, 382, 784	l .	59, 532, 356 104, 382, 784			2. 00 3. 00
3.00	Total (Sull of Titles 1-2)		TION OF OTHER (			DF CAPITAL	3.00
ALLEGATION OF CITIES OF THE COMMITTEE COMMITTE							
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	•		Capi tal -Relate		'		
			d 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	C	5, 375, 977	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	<u> </u>	459, 446		2. 00
3. 00	Total (sum of lines 1-2)	0	0	( C	5, 835, 423	0	3. 00
			St	JMMARY OF CAPIT	IAL		
	Cost Center Description	Interest	Insurance (see	,	Other Capi tal -Relate	Total (2) (sum of cols. 9	
					d Costs (see	through 14)	
		11.00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12. 00	13. 00	14. 00	15. 00	
1. 00	NEW CAP REL COSTS-BLDG & FIXT	252, 084	0	C		5, 628, 061	1. 00
2. 00	NEW CAP REL COSTS-BEDG & TTXT	232,004					2.00
3.00	Total (sum of lines 1-2)	252, 084					
2.00	1 (	2027001	1	1	.1	2,00,700,7	2.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: From 01/01/2019 Provider CCN: 15-0030

				To	com 01/01/2019 12/31/2019		
				Expense Classification on		5/18/2020 9: 30	6 am
				To/From Which the Amount is 1	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - NEW CAP	1. 00 A	2.00 -137,542	3.00 NEW CAP REL COSTS-BLDG &	4. 00	5. 00 11	1. 00
	REL COSTS-BLDG & FIXT (chapter			FLXT			
2. 00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		0	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	2)   Investment income - other   (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time discounts (chapter 8)	В	-12, 491	ADMINISTRATIVE & GENERAL	5. 00	0	4. 00
5. 00	Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	A	-25, 254	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
8. 00	21) Tel evi si on and radi o servi ce		0		0.00	0	8. 00
	(chapter 21)		0				
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician adiustment	A-8-2	-5, 797, 313		0.00	0	9. 00 10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	-2, 590, 191			0	12. 00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	B B	252 424	CAFETERI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee		-353, 430	CAFETERIA	0.00	0	
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
47.00	supplies to other than patients				0.00		47.00
17. 00	Sale of drugs to other than patients		U F 700	MEDICAL DECORDS & LIDDARY	0.00	0	
18. 00	Sale of medical records and abstracts	В		MEDICAL RECORDS & LIBRARY	16. 00	0	
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL			FIXT NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	EQUIP *** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant	A 0 2	0		0.00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00		31. 00
51.00	pathology costs in excess of limitation (chapter 14)	V-0-2	U	DI LLOIT I ATTIOLOGI	06.00		31.00

Provider CCN: 15-0030 Peri od: From 01/01/2019 Worksheet A-8

				T <sub>1</sub>	rom 01/01/2019 o 12/31/2019		
				Expense Classification on	Worksheet A	5/18/2020 9: 3	6 am
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
32. 00	CAH HIT Adjustment for	1.00	2.00	3.00	0.00	0.00	32. 00
	Depreciation and Interest						
33. 00	OTHER OP REV - HUMAN RESOURSEC - MIS	В	-418	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
34. 00	OTHER OP REV - HUMAN RESOURSEC	В	-24, 523	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34. 00
	- INC						
36. 00	OTHER OP REV - PHY REAPP FEES	B B		ADMINISTRATIVE & GENERAL	5.00	0	36. 00
36. 01 36. 02	DI ETARY-OTHER OP REV OTHER OP REV - DI ETARY	В		DI ETARY DI ETARY	10. 00 10. 00	0	36. 01 36. 02
00.02	TRANSFERS		.,,.,2	51217111	.0.00		00.02
38. 00	OTHER OP REV - DI ETARY -	В	-64, 718	CAFETERI A	11. 00	0	38. 00
38. 01	OUTSLDE SAL OTHER OP REV - PHARMACY	В	-977 282	PHARMACY	15. 00	0	38. 01
38. 02	OTHER OF REV - HEALTH PROGRAM	В		ADULTS & PEDIATRICS	30.00	0	38. 02
40.00	OTHER OP REV - MEDICAL RECORDS	1		OPERATING ROOM	50.00	0	40. 00
40. 01	CT SCAN-OTHER OP REV	В		CT SCAN	57.00	0	40. 01
40. 02	OTHER OP REV - LABORATORY-LAB	В	-1, 366	LABORATORY	60. 00	0	40. 02
40. 03	DRUG S OTHER OP REV - AQUATICS - HLTH	В	-17, 203	PHYSICAL THERAPY	66. 00	0	40. 03
	PROG		,				
41. 00	OTHER OP REV - ATH TRAINING -	В	-68, 067	PHYSI CAL THERAPY	66. 00	0	41. 00
42. 00	HLTH P OTHER OP REV - ATH TRAINING -	В	-6 306	PHYSICAL THERAPY	66. 00	0	42. 00
12.00	OUTSI D		0,000		33. 33		12.00
43.00	OTHER OP REV - PHYSICAL THER -	В	-10, 629	PHYSI CAL THERAPY	66. 00	0	43. 00
44. 00	EE OTHER OP REV - PHYSICAL THER -	В	-94 558	PHYSICAL THERAPY	66. 00	0	44. 00
00	FIT F		71,000		33. 33		
44. 01	OTHER OP REV - PHYSICAL THER -	В	-30	OCCUPATI ONAL THERAPY	67. 00	0	44. 01
44. 02	HEALT NC FAMILY INTERNAL	В	-480	RURAL HEALTH CLINIC	88. 00	0	44. 02
11.02	MEDI CI NE-OTHER OP		100	KOIVIE HEXEIN SEI W S	00.00	J	11.02
45. 00	NC FAMILY INTERNAL	В	-1, 120	RURAL HEALTH CLINIC	88. 00	0	45. 00
45. 01	MEDICINE-OTHER OP  OTHER OP REV - NORTHFIELD PARK	В	-44 365	RURAL HEALTH CLINIC II	88. 01	0	45. 01
45. 02	RENT & SERVICES - NCFIM @	В		RURAL HEALTH CLINIC II	88. 01	Ö	45. 02
	NORTHFI ELD	_				_	
45. 03	OTHER OP REV - NEW CASTLE IMMEDIATE	В	-1, 014	RURAL HEALTH CLINIC II	88. 01	0	45. 03
45. 04	OTHER OP REV - NEW CASTLE	В	-47, 717	RURAL HEALTH CLINIC II	88. 01	0	45. 04
	PEDI ATRI CS						
45. 05	OTHER OP REV - NEW CASTLE PEDIATRICS	В	-490	RURAL HEALTH CLINIC II	88. 01	0	45. 05
45. 06	PUBLIC RELATIONS	A	-2, 652	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45. 06
45. 07	PUBLIC RELATIONS	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 07
45.08	PUBLIC RELATIONS	A	-125	NURSING ADMINISTRATION	13.00	0	45. 08
45.09	PUBLIC RELATIONS	A	-1, 605	RADI OLOGY-DI AGNOSTI C	54.00	0	45. 09
45. 10	PUBLIC RELATIONS	A	-986	PHYSI CAL THERAPY	66.00	0	45. 10
45. 11	PUBLIC RELATIONS	A	-5, 983	RURAL HEALTH CLINIC	88.00	0	45. 11
45. 12	PUBLIC RELATIONS	A	-20, 896	RURAL HEALTH CLINIC II	88. 01	0	45. 12
45. 16	PUBLIC RELATIONS	A	-8, 818	EMERGENCY	91. 00	0	45. 16
45. 17	PUBLIC RELATIONS	A	-1, 016	HOME HEALTH AGENCY	101.00	0	45. 17
45. 18	PUBLIC RELATIONS	A		HOSPI CE	116. 00	0	45. 18
45. 19	AHA & IHA DUES	A	-7, 333	ADMINISTRATIVE & GENERAL	5. 00	0	45. 19
46. 00	BENEFIT EXPENSE	A	2, 905, 650	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	46. 00
46. 01	NC FAMILY INTERNAL	В	-136, 761	RURAL HEALTH CLINIC	88. 00	0	46. 01
46. 02	MEDI CI NE-OTHER OP   MEDI CAL DI RECTOR	A	90 846	NURSING ADMINISTRATION	13. 00	0	46. 02
46. 03	HAF EXPENSE	A		ADMI NI STRATI VE & GENERAL	5. 00	0	46. 03
46. 04	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00	Ö	46. 04
46. 05	PHYSICIAN RECRUITMENT	A		ADULTS & PEDIATRICS	30. 00	Ō	46. 05
46. 06	PHYSICIAN RECRUITMENT	A		OPERATING ROOM	50. 00	0	46. 06
46. 07	PHYSICIAN RECRUITMENT	A		EMERGENCY	91.00	0	46. 07
50.00	TOTAL (sum of lines 1 thru 49)		-10, 324, 660				50.00
	(Transfer to Worksheet A,		•				
	column 6, line 200.)						

<sup>(1)</sup> 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.

Health Financial Systems	HE	NRY COUNTY MEM	ORIAL HOSPITAL	In Li€	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 01/01/2019 To 12/31/2019	Date/Time Pre 5/18/2020 9:3	
			Expense Classification or			
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4. 00	5. 00	

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

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

Provider CCN: 15-0030

Worksheet A-8-1

From 01/01/2019

				lo 12/31/2019	Date/lime Pre   5/18/2020 9:3	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		_			
1.00		CT SCAN	CT SCAN-PAID TO FND	207, 505		1. 00
2.00	58. 00	MAGNETIC RESONANCE IMAGING (	MRI-PAID TO FND	154, 772	450, 000	2. 00
3.00	66. 00	PHYSI CAL THERAPY	PHYSI CAL THERAPY-RENT	164, 368	784, 622	3.00
3. 01	5. 00	ADMINISTRATIVE & GENERAL	ADMI NI STRATI ON-RENT	0	22, 550	3. 01
4.00	65. 00	RESPI RATORY THERAPY	SLEEP LAB-RENT	22, 090	49, 678	4.00
4. 01	88. 00	RURAL HEALTH CLINIC	NC FAMILY INTERNAL MEDICINE-	220, 565	496, 024	4. 01
4.02	88. 01	RURAL HEALTH CLINIC II	NCFIM @ NORTHFIELD PARK-RENT	329, 431	737, 171	4. 02
4.03	88. 01	RURAL HEALTH CLINIC II	NCFIM @ NORTHFIELD PARK-RENT	69, 950	156, 528	4. 03
4.04	88. 01	RURAL HEALTH CLINIC II	NCFIM @ NORTHFIELD PARK-RENT	144, 330	323, 328	4.04
4.05	101.00	HOME HEALTH AGENCY	HOME CARE-RENT	7, 849	21, 975	4.05
4.06	116. 00	HOSPI CE	HOSPI CE-RENT	7, 846	21, 975	4.06
4.07	60.00	LABORATORY	LABORATORY- RENT	5, 443	33, 439	4. 07
5.00	TOTALS (sum of lines 1-4).			1, 334, 149	3, 924, 340	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					
* The	amounta on Linea 1 4 (and out		transformed in datail to Wark	ahaa+ A aalumn	/ 1:	

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

nas n	that been posted to worksheet A, cordinins I and/or 2, the amount arrowable should be mare attend in cordinin 4 or this part.						
				Related Organization(s) and/	or Home Office		
	Symbol (1)	Name	Percentage of	Name	Percentage of		
			Ownershi p		Ownershi p		
	1. 00	2.00	3.00	4. 00	5. 00		
· ·	B. INTERRELATIONSHIP TO 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
	G. Other (financial or	MISC			100.00
	non-financial) specify:				

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

3.00

3.01

4.00

4 01

4.02

4.03

4.04

4.05

4.06

4.07

5.00 | -2,590,191 | 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 RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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

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

0

0

0

0

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0

3.00

3.01

4.00

4 01

4.02

4.03

4.04

4.05

4.06

4.07

-620, 254

-22, 550

-27, 588

-275, 459

-407, 740

-86, 578

-178, 998

-14, 126

-14, 129

-27, 996

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 01/01/2019 To 12/31/2019 Date/Time Prepared: Provider CCN: 15-0030

					-	Γο 12/31/2019	Date/Time Pre 5/18/2020 9:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·			Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		LABORATORY	56, 000		,		588	
2.00		ADULTS & PEDIATRICS	2, 134, 580			2.1,000		
3.00		OPERATING ROOM	2, 539, 960			2077 100		
4.00		RURAL HEALTH CLINIC II	1, 122, 773		0	211, 500		
5.00	0. 00		0		0	0	0	0.00
6.00	0.00		0	0	0	0	0	0.00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	
9.00	0. 00		0	0	0	0	0	7.00
10. 00	0. 00		0	0	0	0	0	10.00
200.00			5, 853, 313					200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE			of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
	1. 00	2.00	8.00	9. 00	Education 12.00	12 13. 00	14.00	
1. 00		LABORATORY	73, 585				14.00	1.00
2. 00		ADULTS & PEDIATRICS	73,303			-	-	1
3. 00		OPERATING ROOM	0	· ·	_	1	1	1
4. 00		RURAL HEALTH CLINIC II		0	0	0	0	1
5. 00	0.00		0	0	0	0	0	
6. 00	0.00		0	0	0	0	0	i
7. 00	0.00		0	0	0	0	0	1
8. 00	0.00		0	0	0	0	0	8. 00
9. 00	0.00		0	0	0	0	0	1
10. 00	0.00		0	0	0	0	0	1
200.00			73, 585	3, 679	0	l o	l o	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance	,		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		LABORATORY	0	,		_	I .	1. 00
2.00		ADULTS & PEDIATRICS	0	"	_	_, ,		2. 00
3.00		OPERATING ROOM	0	0	0	2,007,700	•	3. 00
4.00		RURAL HEALTH CLINIC II	0	0	0	1, 122, 773		4. 00
5.00	0. 00		0	0	0	0		5. 00
6.00	0.00		0	0	0	0		6. 00
7. 00	0.00		0	0	0	0		7. 00
8.00	0.00		0	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			0	73, 585	0	5, 797, 313		200.00

In Lieu of Form CMS-2552-10 Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0030 Peri od: Worksheet B From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 5/18/2020 9:36 am CAPITAL RELATED COSTS Cost Center Description Net Expenses NEW BLDG & NEW MVBLE **EMPLOYEE** Subtotal for Cost FIXT **FOULP BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 5, 628, 061 00100 NEW CAP REL COSTS-BLDG & FIXT 5, 628, 061 1 00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 459, 446 459, 446 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 16, 097, 032 33, 679 2,612 16, 133, 323 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 13 227 589 778, 291 60 363 2 103 581 16, 169, 824 5 00 4, 891, 609 7.00 00700 OPERATION OF PLANT 2, 853, 071 1, 488, 571 115, 450 434, 517 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 405, 580 74, 381 5, 769 485, 730 8.00 00900 HOUSEKEEPI NG 828, 748 43, 202 3, 351 180, 764 1, 056, 065 9.00 9.00 01000 DI ETARY 10.00 417 995 679, 105 156, 937 92,001 10 00 12, 172 11.00 01100 CAFETERI A 184, 281 42, 876 3, 325 125, 346 355, 828 11.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0030

Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Ti me Prepared:

5/18/2020 9:36 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 16, 169, 824 5 00 5 00 7.00 00700 OPERATION OF PLANT 992, 258 5, 883, 867 7.00 00800 LAUNDRY & LINEN SERVICE 98, 530 677, 702 8.00 93, 442 8.00 9.00 00900 HOUSEKEEPI NG 214, 222 54, 273 28, 757 1, 353, 317 9.00 01000 DI ETARY 137, 756 197, 153 1, 060, 138 10.00 10.00 7.724 38, 400 11.00 01100 CAFETERI A 72, 179 53, 863 0 11, 687 11.00 0 13 00 01300 NURSING ADMINISTRATION 665, 703 108, 273 0 8, 348 0 13.00 01400 CENTRAL SERVICES & SUPPLY 245, 665 195, 378 0 5.724 14.00 14 00 0 15.00 01500 PHARMACY 700, 525 42, 665 0 10, 018 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 231, 809 75, 250 4.770 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 855, 433 03000 ADULTS & PEDIATRICS 1, 332, 267 811, 830 136, 511 356, 814 31.00 03100 INTENSIVE CARE UNIT 446, 667 316, 871 30, 841 81,094 204, 705 31.00 185, 223 43 00 43.00 04300 NURSERY 83,800 11,007 6, 440 ANCILLARY SERVICE COST CENTERS 50.00 1, 050, 361 450, 901 121, 846 50.00 05000 OPERATING ROOM 176, 976 0 05200 DELIVERY ROOM & LABOR ROOM 51, 399 42, 583 2,837 10, 972 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 622, 281 309, 250 49, 315 52, 234 0 54.00 05700 CT SCAN 57.00 112.534 11.964 0 0 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 69, 946 14, 613 0 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION C 0 59.00 60.00 06000 LABORATORY 1,030,543 857 60.00 225, 642 33.392 0 06001 BLOOD LABORATORY 60.01  $\cap$ Λ 60.01 65.00 06500 RESPIRATORY THERAPY 213, 861 90, 546 0 34, 346 0 65.00 06600 PHYSI CAL THERAPY 97, 790 66.00 458, 609 708, 255 13, 259 0 66.00 06700 OCCUPATIONAL THERAPY 6, 992 67.00 67.00 60.349 1.666 12.403 0 06800 SPEECH PATHOLOGY 68.00 26, 180 5, 272 C 0 68.00 69.00 06900 ELECTROCARDI OLOGY 85, 591 0 6, 201 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 311, 632 0 0 0 71.00 0 72 00 07200 IMPL. DEV. CHARGED TO PATIENT 1, 103, 339 Ω O 0 0 72 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 C 0 0 73.00 03950 CARDI AC REHAB 40, 589 0 76.00 76.00 0 OUTPATIENT SERVICE COST CENTERS 1, 118, 494 88.00 88.00 08800 RURAL HEALTH CLINIC 430, 634 4, 213 36, 492 0 88. 01 08801 RURAL HEALTH CLINIC II 1, 733, 271 1, 113, 131 131, 897 0 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 89.00 91 00 09100 EMERGENCY 937.657 288, 655 121, 400 111, 385 0 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 363, 407 62, 549 0 9, 540 0 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 183, 607 0 116.00 62, 522 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 14, 896, 454 5, 856, 307 1, 060, 138 118. 00 530, 233 1, 236, 923 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 4.450 27, 560 3.101 192.00 19200 PHYSICIANS' PRIVATE OFFICES 423, 798 0 192.00 336 194. 00 07950 HOSPI TALI ST C 0 0 0 194 00 194. 01 07951 RENTAL 23, 733 105, 184 0 194. 01 194. 05 07955 OTHER NONREIMBURSABLE COSTS 34, 284 14, 350 0 0 194. 05 194.06 07956 DR AFZAL 0 194.06 1, 761 0 0 194. 07 194. 07 07957 PHILLIPS HALL 5.503 8, 109 194.08 07958 OB DRS 9,094 0 194. 08 0 194. 09 07959 THE WATERS 0 0 194. 09 225, 249 118, 186 0 194. 10 07960 CAMBRIDGE CITY 0 194, 10 160, 126 0 194. 11 07961 WELL BEING 25, 458 0 0 0 194. 11 0 194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC 13, 413 0 0 194. 12 194. 13 07963 NEW CASTLE PEDIATRICS 0 194. 13 0 0 194. 14 07964 HENRY COUNTY RADI OLOGY 0 0 361, 098 C 0 194, 14 194. 15 07965 HENRY COUNTY ANESTHESI OLOGY 0 0 194. 15 194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY o 0 0 0 194. 16 Cross Foot Adjustments 200. 00 200.00 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 5, 883, 867 677, 702 1, 353, 317 1, 060, 138 202. 00 202.00 16, 169, 824

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0030

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2019	Part
To 12/31/2019	Date/Time Prepared:
5/18/2020 9:36 am	

			10	12/31/2019	5/18/2020 9: 3	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
·		ADMI NI STRATI ON			RECORDS &	
			SUPPLY		LIBRARY	
OFNEDAL CERVILOR COCT OFNITERS	11.00	13. 00	14. 00	15. 00	16. 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   O0200   NEW CAP REL COSTS-MVBLE EQUIP 4.00   O0400   EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00   00500 ADMINISTRATIVE & GENERAL						5.00
7. 00   00700   OPERATION OF PLANT						7.00
8. 00   00800   LAUNDRY & LINEN SERVICE						8.00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	493, 557					11.00
13. 00 01300 NURSI NG ADMINI STRATI ON	40, 061	4, 104, 152				13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	12, 820		1, 670, 659			14. 00
15. 00 01500 PHARMACY	0	0	2, 740	4, 209, 378		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	24, 037	O	2, 572	0	1, 481, 205	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				•		
30. 00 03000 ADULTS & PEDIATRICS	89, 738	806, 430	31, 680	0	157, 746	30. 00
31.00 03100 INTENSIVE CARE UNIT	25, 639	230, 409	14, 079	0	84, 029	31. 00
43. 00 04300 NURSERY	9, 615	86, 403	9, 679	0	58, 820	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	72, 111		100, 379	0	284, 554	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	3, 205		2, 495	0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	36, 857	0	31, 631	0	214, 274	54.00
57. 00   05700   CT   SCAN	3, 205		12, 981	0	78, 300	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 205		3, 160	0	14, 896	
59. 00   05900   CARDI AC CATHETERI ZATI ON 60. 00   06000   LABORATORY	0 F2 001	0	101 272	0	0	59.00
60. 00   06000  LABORATORY 60. 01   06001  BLOOD LABORATORY	52, 881 0		191, 272 0	0	227, 261 0	60. 00 60. 01
65. 00   06500   RESPI RATORY   THERAPY	14, 422		5, 172	0	11, 840	1
66. 00   06600   PHYSI CAL THERAPY	40, 061	0	7, 178	0	9, 167	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	4, 807	0	7, 170	0	1, 146	1
68. 00 06800 SPEECH PATHOLOGY	1, 602		0	0	382	68. 00
69. 00   06900   ELECTROCARDI OLOGY	3, 205		7, 668	0	12, 222	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0, 200	0	292, 264	o o	27, 119	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	o o	884, 883	o	41, 633	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		0	4, 209, 378	0	73. 00
76. 00   03950   CARDI AC   REHAB	3, 205	28, 801	525	0	1, 528	1
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	763, 228	6, 661	0	12, 986	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	1, 036, 838	11, 288	0	20, 625	1
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
91. 00   09100   EMERGENCY	52, 881	475, 218	44, 617	0	213, 892	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS			F ((4)	ما	F 700	101 00
101. 00 10100 HOME HEALTH AGENCY	0	0	5, 664	0	5, 729	101. 00
SPECIAL PURPOSE COST CENTERS  113. 00 11300   INTEREST EXPENSE	T					112 00
114.00 11400 UTILI ZATION REVIEW-SNF						113. 00 114. 00
116. 00 11600 HOSPI CE	0	0	2, 071	0	3 056	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	493, 557			4, 209, 378	1, 481, 205	
NONREI MBURSABLE COST CENTERS	473, 337	4, 104, 132	1,070,037	4, 207, 370	1, 401, 203	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ol	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0		0	0		192. 00
194. 00 07950 HOSPI TALI ST	0		o	o		194. 00
194. 01 07951 RENTAL	0	0	0	0	0	194. 01
194.05 07955 OTHER NONREIMBURSABLE COSTS	0	0	0	o	0	194. 05
194.06 07956 DR AFZAL	0	0	0	0	0	194. 06
194. 07 07957 PHI LLI PS HALL	0	0	0	0	0	194. 07
194.08 07958 OB DRS	0	0	0	0	0	194. 08
194.09 07959 THE WATERS	0	0	0	0	0	194. 09
194. 10 07960 CAMBRIDGE CITY	0	0	0	0	0	194. 10
194. 11 07961 WELL BEING	0	0	0	0	0	194. 11
194.12 07962 ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	O		194. 12
194. 13 07963 NEW CASTLE PEDIATRICS	0	0	0	0		194. 13
194. 14 07964 HENRY COUNTY RADI OLOGY	0	0	0	0		194. 14
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY	0	0	0	0		194. 15
194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194. 16
200.00 Cross Foot Adjustments	_	_	_	_	=	200. 00
201.00 Negative Cost Centers	100 555	0	0	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	493, 557	4, 104, 152	1, 670, 659	4, 209, 378	1, 481, 205	J2U2. UU

| Peri od: | Worksheet B | From 01/01/2019 | Part | | To 12/31/2019 | Date/Time Prepared: | To 12/31/2019 | Date/Time Prepared: | To 12/31/2019 | Date/Time Prepared: | To 12/31/2019 | To 12/ Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0030

				То	12/31/2019   Date/Time Pro 5/18/2020 9:3	
	Cost Center Description	Subtotal	Intern &	Total	37 107 2020 7. 3	JO alli
	'		Residents Cost			
			& Post			
			Stepdown Adjustments			
		24. 00	25. 00	26. 00		
	GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8. 00
9.00	00900 HOUSEKEEPI NG					9. 00
10. 00	01000 DI ETARY					10. 00
11.00	01100 CAFETERI A					11.00
13. 00 14. 00	O1300   NURSI NG ADMI NI STRATI ON   O1400   CENTRAL SERVI CES & SUPPLY					13. 00 14. 00
15. 00	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	11, 146, 226	0	11, 146, 226		30.00
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY	3, 636, 302 1, 364, 095	0	3, 636, 302 1, 364, 095		31. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	1, 304, 095	U	1, 364, 095		43.00
50.00	05000 OPERATING ROOM	8, 083, 197	0	8, 083, 197		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	395, 677	0	395, 677		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 383, 547	0	4, 383, 547		54.00
57. 00	05700 CT SCAN	773, 753	0	773, 753		57. 00
58. 00 59. 00	05800   MAGNETIC RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	450, 640 0	0	450, 640 0		58. 00 59. 00
60.00	06000 LABORATORY	6, 842, 194	0	6, 842, 194		60.00
60. 01	06001 BLOOD LABORATORY	0, 012, 171	Ö	0, 012, 171		60. 01
65.00	06500 RESPI RATORY THERAPY	1, 424, 475	0	1, 424, 475		65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 595, 156	0	3, 595, 156		66. 00
67. 00	06700 OCCUPATIONAL THERAPY	384, 869	0	384, 869		67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	162, 499 536, 833	0	162, 499 536, 833		68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 167, 293	0	2, 167, 293		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	7, 469, 066	0	7, 469, 066		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 209, 378	0	4, 209, 378		73. 00
76. 00	03950 CARDI AC REHAB	274, 743	0	274, 743		76. 00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	7, 886, 633	O	7, 886, 633		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	12, 591, 853	0	12, 591, 853		88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89. 00
91.00	09100 EMERGENCY	6, 868, 142	0	6, 868, 142		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	2, 238, 404	0	2, 238, 404		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	2, 230, 404	0	2, 230, 404		1101.00
113.00	11300   NTEREST EXPENSE					113. 00
	11400 UTILIZATION REVIEW-SNF					114. 00
	11600 HOSPI CE	1, 156, 395	0	1, 156, 395		116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)     NONREIMBURSABLE COST CENTERS	88, 041, 370	0	88, 041, 370		118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	57, 049	0	57, 049		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	2, 513, 362	О	2, 513, 362		192. 00
	07950 HOSPI TALI ST	0	0	0		194. 00
	07951 RENTAL	245, 916	0	245, 916		194. 01
	07955 OTHER NONREIMBURSABLE COSTS 07956 DR AFZAL	217, 645 10, 442	0	217, 645 10, 442		194. 05 194. 06
	07957 PHILLIPS HALL	13, 612	o	13, 612		194. 07
	07958 OB DRS	9, 094	0	9, 094		194. 08
	07959 THE WATERS	1, 453, 861	0	1, 453, 861		194. 09
	07960 CAMBRI DGE CI TY	949, 513	0	949, 513		194. 10
	07961 WELL BEING   07962 ACTIVATE HEALTH EMPLOYER CLINIC	150, 958 79, 535	0	150, 958 79, 535		194. 11 194. 12
	07963 NEW CASTLE PEDIATRICS	79, 535 0	0	/ <del>7</del> , 333		194. 12
	07964 HENRY COUNTY RADI OLOGY	2, 141, 230	0	2, 141, 230		194. 14
194. 15	07965 HENRY COUNTY ANESTHESI OLOGY	0	O	0		194. 15
	07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0		194. 16
200. 00 201. 00		0	0	0		200. 00 201. 00
201.00		95, 883, 587	0	95, 883, 587		201.00
00	, , , , , , , , , , , , , , , , , , ,	,,,	,			

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To | 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0030

			Ť	12/31/2019	Date/Time Pre 5/18/2020 9:3	
		CAPI TAL REL	ATED COSTS		77 107 2020 7. 3	o am
Cost Center Description	Directly Assigned New Capital	NEW BLDG & FIXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	Related Costs 0	1. 00	2.00	2A	4. 00	
GENERAL SERVICE COST CENTERS		1.00	2.00	Zn	4.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2. 00   00200   NEW CAP REL COSTS-MVBLE EQUI P		22 (70	2 /12	27 201	27, 201	2.00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT 5.00   00500   ADMINISTRATIVE & GENERAL	0	33, 679 778, 291	2, 612 60, 363	36, 291 838, 654	36, 291 4, 734	4. 00 5. 00
7. 00   00700   OPERATION OF PLANT		1, 488, 571	115, 450	1, 604, 021	978	7. 00
8.00   00800 LAUNDRY & LINEN SERVICE	o	74, 381	5, 769	80, 150	0	8. 00
9. 00   00900   HOUSEKEEPI NG	0	43, 202	3, 351	46, 553	407	9. 00
10. 00   01000   DI ETARY	0	156, 937	12, 172	169, 109	207	10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG ADMI NI STRATI ON	0	42, 876 86, 187	3, 325 6, 684	46, 201 92, 871	282 1, 723	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY		155, 523		167, 585	382	14. 00
15. 00 01500 PHARMACY	o	33, 962	2, 634	36, 596	0	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	59, 900	4, 646	64, 546	556	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	O	646, 227	50, 120	696, 347	4, 034	30. 00
31. 00   03100   NTENSI VE CARE UNI T		252, 233		271, 796	4, 034 995	31.00
43. 00   04300 NURSERY	o	66, 706	5, 174	71, 880	454	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   0PERATING ROOM	0	358, 923	27, 837	386, 760	3, 538	50.00
52.00   O5200   DELIVERY ROOM & LABOR ROOM   54.00   O5400   RADIOLOGY-DIAGNOSTIC	0	33, 896 246, 167	2, 629 19, 092	36, 525 265, 259	117 1, 297	52. 00 54. 00
57. 00   05700 CT SCAN	o	9, 523	739	10, 262	146	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	o	11, 632	902	12, 534	87	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	0	179, 614	13, 930	193, 544	1, 572 0	60. 00 60. 01
65. 00 06500 RESPIRATORY THERAPY		37, 745	2, 927	40, 672	506	65. 00
66. 00   06600 PHYSI CAL THERAPY	o	21, 547	1, 671	23, 218	1, 232	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	5, 566	432	5, 998	166	67. 00
68. 00   06800   SPEECH   PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY	0	4, 196	325 0	4, 521	71 149	68. 00 69. 00
69.00   06900   ELECTROCARDI OLOGY 71.00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	0	0	o	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 00 03950 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS	0	15, 459	1, 199	16, 658	97	76. 00
88. 00   08800   RURAL HEALTH CLINIC	l	0	0	ol	2, 878	88. 00
88. 01   08801 RURAL HEALTH CLINIC II	o	0	0	Ō	4, 814	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
91.00   09100   EMERGENCY 92.00   09200   0BSERVATION   BEDS (NON-DISTINCT PART)	0	229, 774	17, 821	247, 595	2, 029	91. 00 92. 00
92. 00   09200  OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				<u>U</u>		92.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	874	101. 00
SPECIAL PURPOSE COST CENTERS			Γ			
113. 00 11300 INTEREST_EXPENSE 114. 00 11400 UTI LI ZATI ON_REVI EW-SNF						113. 00 114. 00
116. 00 11600 HOSPI CE	o	0	0	О	344	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	5, 072, 717	393, 429	5, 466, 146	34, 669	
NONREI MBURSABLE COST CENTERS		04 000	_	04 000		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	21, 938	0	21, 938		190. 00 192. 00
194. 00 07950 HOSPI TALI ST		0	Ö	ő		194. 00
194. 01 07951 RENTAL	o	0	24, 647	24, 647		194. 01
194. 05 07955 OTHER NONREI MBURSABLE COSTS	0	0	0	0		194. 05
194. 06 07956 DR AFZAL 194. 07 07957 PHI LLI PS HALL	0	0	0	0		194. 06 194. 07
194. 08 07958 OB DRS		0	0	o		194. 07
194. 09 07959 THE WATERS	o	533, 406	41, 370	574, 776		194. 09
194. 10 07960 CAMBRIDGE CITY	0	0	0	0		194. 10
194. 11 07961 WELL BEING	0	0	0	0		194. 11
194. 12 07962 ACTIVATE HEALTH EMPLOYER CLINIC 194. 13 07963 NEW CASTLE PEDIATRICS		0	0	0		194. 12 194. 13
194. 14 07964 HENRY COUNTY RADIOLOGY		0	Ö	ő		194. 13
194. 15 07965 HENRY COUNTY ANESTHESI OLOGY	0	0	0	o	0	194. 15
194. 16 07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194. 16
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0	_	0	0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	o	5, 628, 061	459, 446	6, 087, 507	36, 291	
			•			

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0030

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2019 Part II
To 12/31/2019 Date/Time Prepared:
5/18/2020 9:36 am

				''	0 12/31/2019	5/18/2020 9: 3	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	2.22	10.00	
	CENIEDAL CEDIVICE COCT CENTEDO	5. 00	7. 00	8.00	9. 00	10. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	843, 388					5. 00
7.00	00700 OPERATION OF PLANT	51, 753	1, 656, 752				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	5, 139	26, 311	111, 600			8. 00
9.00	00900 HOUSEKEEPI NG	11, 173	15, 282	4, 736	78, 151		9. 00
10.00	01000 DI ETARY	7, 185	55, 513	1, 272	2, 218	235, 504	10. 00
11. 00	01100 CAFETERI A	3, 765	15, 167	1		0	11. 00
13.00	01300 NURSING ADMINISTRATION	34, 721	30, 487			0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	12, 813	55, 014	1	331	0	14. 00
15. 00	01500 PHARMACY	36, 537	12, 013			0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	12, 090	21, 189	0	275	0	16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	69, 487	228, 591	22, 479	20, 607	190, 030	30.00
31. 00	03100   NTENSI VE CARE UNIT	23, 297	89, 223	1		45, 474	31.00
43. 00	04300 NURSERY	9, 661	23, 596	1	372	45, 474	43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	7,001	23, 370	1,013	372		43.00
50.00	05000 OPERATING ROOM	54, 784	126, 963	20, 065	10, 220	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 681	11, 990	1	634	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	32, 456	87, 077	1	3, 016	0	54.00
57.00	05700 CT SCAN	5, 869	3, 369	0	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 648	4, 115	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	53, 750	63, 535	141	1, 928	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	11, 154	25, 496		1, 983	0	65. 00
66.00	06600 PHYSI CAL THERAPY	23, 920	199, 427	1		0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY	3, 148	1, 969	1	716	0	67.00
69. 00	06800   SPEECH PATHOLOGY   06900   ELECTROCARDI OLOGY	1, 365 4, 464	1, 484		358	0	68. 00 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 254	0		336	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	57, 547	0		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ö		0	0	73.00
76. 00	03950 CARDI AC REHAB	2, 117	O	o o	o	0	76. 00
	OUTPATIENT SERVICE COST CENTERS			•	'		
88. 00	08800 RURAL HEALTH CLINIC	58, 337	121, 256	694	2, 107	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	90, 422	313, 430	0	7, 617	0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
91.00	09100 EMERGENCY	48, 905	81, 278	19, 992	6, 432	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS  10100 HOME HEALTH AGENCY	18, 954	17, 612	2 0	551	0	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	10, 754	17,012	-1	331		1101.00
113.00	11300   I NTEREST EXPENSE						113. 00
114.00	11400 UTILIZATION REVIEW-SNF						114. 00
116. 00	11600 H0SPI CE	9, 576					116. 00
118. 00		776, 972	1, 648, 992	87, 316	71, 430	235, 504	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	232	7, 760				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	22, 104	0	55	1		192.00
	07950 H0SPI TALI ST 07951 RENTAL	1 220	0	1			194. 00
	07955 OTHER NONREIMBURSABLE COSTS	1, 238	0	0	-,		194. 01 194. 05
	07956 DR AFZAL	1, 788 92	0	2, 363	0		194. 05
	07957 PHILLIPS HALL	0	0	906	468		194. 07
	07958 OB DRS		0	1, 498			194. 08
	07959 THE WATERS	11, 748	Ö	19, 462	l .		194. 09
	07960 CAMBRI DGE CITY	8, 352	O	0			194. 10
	07961 WELL BEING	1, 328	O	o	0		194. 11
194. 12	07962 ACTIVATE HEALTH EMPLOYER CLINIC	700	O	0	o		194. 12
	07963 NEW CASTLE PEDIATRICS	0	0	0	o		194. 13
	07964 HENRY COUNTY RADI OLOGY	18, 834	O	) o	0		194. 14
	07965 HENRY COUNTY ANESTHESI OLOGY	0	0	0	0		194. 15
	07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194. 16
200.00						1	200. 00
201.00		0 42 222	1 /5/ 350	0	0 70 454		201.00
202. 00	TOTAL (sum lines 118 through 201)	843, 388	1, 656, 752	111, 600	78, 151	235, 504	J2U2. UU

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0030

				Ic	12/31/2019	Date/lime Pre   5/18/2020 9:3	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	O alli
	·		ADMI NI STRATI ON	SERVICES &		RECORDS &	
		11 00	40.00	SUPPLY	45.00	LI BRARY	
GE	ENERAL SERVICE COST CENTERS	11. 00	13. 00	14. 00	15. 00	16. 00	
	0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
	D200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
	0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00	D500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00	0700 OPERATION OF PLANT						7. 00
	D800 LAUNDRY & LINEN SERVICE						8. 00
	0900 HOUSEKEEPI NG						9. 00
	1000 DI ETARY						10.00
	1100 CAFETERI A	66, 090	4/5 /40				11.00
	1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY	5, 364 1, 717	165, 648 0	227 042			13. 00 14. 00
1	1500 PHARMACY	1, /1/	0	237, 842 390	86, 114		15. 00
	1600 MEDICAL RECORDS & LIBRARY	3, 219	0	366	00, 114	102, 241	1
	NPATIENT ROUTINE SERVICE COST CENTERS	0,2.,	<u> </u>	555	<u>~</u> 1	102,211	10.00
	BOOO ADULTS & PEDIATRICS	12, 018	32, 548	4, 510	0	10, 888	30. 00
31. 00 03	3100 INTENSIVE CARE UNIT	3, 433	9, 300	2, 004	0	5, 800	31. 00
	4300 NURSERY	1, 287	3, 487	1, 378	0	4, 060	43. 00
	NCILLARY SERVICE COST CENTERS	0.757	0/ 455	4.4.000		10 (10	
	5000 OPERATING ROOM 5200 DELIVERY ROOM & LABOR ROOM	9, 656 429	26, 155 1 143	14, 290 355	0	19, 643 0	50. 00 52. 00
	5400 RADI OLOGY-DI AGNOSTI C	4, 935	1, 162 0	4, 503	0	14, 790	1
	5700 CT SCAN	4, 733	0	1, 848	0	5, 405	1
	5800 MAGNETIC RESONANCE IMAGING (MRI)	429	0	450	0	1, 028	
	5900 CARDI AC CATHETERI ZATI ON	0	Ö	0	Ö	0	59. 00
	6000 LABORATORY	7, 081	0	27, 231	0	15, 687	60.00
60. 01 06	6001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 06	5500 RESPIRATORY THERAPY	1, 931	0	736	0	817	65.00
	6600 PHYSI CAL THERAPY	5, 364	0	1, 022	0	633	66. 00
	5700 OCCUPATI ONAL THERAPY	644	0	0	0	79	67. 00
	SPEECH PATHOLOGY	215	0	0	0	26	1
	5900 ELECTROCARDI OLOGY	429	0	1, 092	0	844	69. 00
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	41, 608	0	1, 872	71.00
	7200 IMPL. DEV. CHARGED TO PATIENT 7300 DRUGS CHARGED TO PATIENTS	0	0	125, 976 0	0 04 114	2, 874 0	72. 00 73. 00
	3950 CARDI AC REHAB	429	1, 162	75	86, 114 0	105	1
	JTPATIENT SERVICE COST CENTERS	127	1, 102	, 0	<u> </u>	100	70.00
	B800 RURAL HEALTH CLINIC	0	30, 805	948	0	896	88. 00
	B801 RURAL HEALTH CLINIC II	0	41, 849	1, 607	0	1, 424	88. 01
	B900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
	9100 EMERGENCY	7, 081	19, 180	6, 352	0	14, 764	
	P200 OBSERVATION BEDS (NON-DISTINCT PART) THER REIMBURSABLE COST CENTERS						92.00
	0100 HOME HEALTH AGENCY	0	0	806	0	395	101. 00
	PECIAL PURPOSE COST CENTERS		Ψ,	333	<u> </u>	0.70	
	1300   NTEREST EXPENSE						113. 00
	1400 UTI LI ZATI ON REVI EW-SNF						114. 00
	1600 HOSPI CE	0	0	295	0 111		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   ONREIMBURSABLE COST CENTERS	66, 090	165, 648	237, 842	86, 114	102, 241	1118.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	O	0	190. 00
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	ő	0	Ö		192. 00
	7950 HOSPI TALI ST	0	0	0	o		194. 00
	7951 RENTAL	0	0	0	0		194. 01
	7955 OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194. 05
194. 06 07	7956 DR AFZAL	0	0	0	0	0	194. 06
	7957 PHI LLI PS HALL	0	0	0	0		194. 07
	7958 OB DRS	0	0	0	0		194. 08
	7959 THE WATERS	0	0	0	0		194. 09
	7960 CAMBRIDGE CITY 7961 WELL BEING		0	0	O		194. 10 194. 11
1	7961 WELL BEING 7962 ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0		194. 11
	7963 NEW CASTLE PEDIATRICS		n	0	0		194. 12
1	7964 HENRY COUNTY RADIOLOGY	o o	n	0	ol		194. 14
	7965 HENRY COUNTY ANESTHESI OLOGY	o	o	0	o		194. 15
194. 16 07	7966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	o	0	О		194. 16
200. 00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0		0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	66, 090	165, 648	237, 842	86, 114	102, 241	202.00

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To | 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0030

				Γ	To 12/31/2019 Date/Time Pr 5/18/2020 9:	
	Cost Center Description	Subtotal	Intern &	Total	37 107 2020 7.	JO dill
			Residents Cost			
			& Post Stepdown			
			Adjustments			
	I	24. 00	25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS  OO100 NEW CAP REL COSTS-BLDG & FIXT		I	I		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00 8. 00	00700 OPERATION OF PLANT					7. 00 8. 00
9. 00	O0800   LAUNDRY & LINEN SERVICE   O0900   HOUSEKEEPING					9.00
10. 00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
	01300 NURSI NG ADMI NI STRATI ON					13.00
	01400   CENTRAL SERVI CES & SUPPLY   01500   PHARMACY					14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY			•		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	1, 291, 539	1			30.00
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY	461, 084 117, 988	1			31. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS	117, 700	,	117, 700	1	73.00
50.00	05000 OPERATING ROOM	672, 074	1	1		50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	54, 360	1	1		52. 00
54. 00 57. 00	05400  RADI OLOGY-DI AGNOSTI C   05700  CT SCAN	421, 454 27, 328	1	1		54. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	22, 291		1		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	. 0	l .	1		59. 00
60.00	06000 LABORATORY	364, 469	l e		2	60.00
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0 83, 295	0		)	60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	262, 646	l .	1		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	12, 994	1			67. 00
68. 00	06800 SPEECH PATHOLOGY	7, 682	1	,		68. 00
69. 00 71. 00	06900  ELECTROCARDIOLOGY   07100  MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 336 59, 734	1			69. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	186, 397	1	1		71.00
	07300 DRUGS CHARGED TO PATIENTS	86, 114				73. 00
76. 00	03950 CARDI AC REHAB	20, 643	0	20, 643	3	76. 00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	217, 921	1 0	217, 921		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	461, 163	1	1		88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1			89. 00
91. 00	09100 EMERGENCY	453, 608	1	1	3	91. 00
92. 00	O9200   OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
101.00	10100 HOME HEALTH AGENCY	39, 192	. 0	39, 192		101.00
	SPECIAL PURPOSE COST CENTERS			3.7		
	11300   I NTEREST EXPENSE					113. 00
	11400 UTILIZATION REVIEW-SNF  11600 HOSPICE	28, 031	0	28, 031		114. 00 116. 00
118.00	1	5, 359, 343		l		118.00
	NONREI MBURSABLE COST CENTERS		-			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	30, 109	l e	,		190. 00
	19200   PHYSI CLANS' PRI VATE OFFI CES   07950   HOSPI TALI ST	23, 031	l			192. 00 194. 00
	07950 ROSPITALIST	31, 959		1		194. 00
	07955 OTHER NONREIMBURSABLE COSTS	4, 151	1	1		194. 05
	07956 DR AFZAL	92	l .	1		194. 06
	07957 PHILLIPS HALL	1, 374	1			194. 07
	07958   OB   DRS     07959   THE   WATERS	1, 498 606, 194		.,		194. 08 194. 09
	07960 CAMBRI DGE CI TY	8, 702	l .			194. 10
194. 11	07961 WELL BEING	1, 385		,		194. 11
	07962 ACTIVATE HEALTH EMPLOYER CLINIC	700	1			194. 12
	07963   NEW CASTLE PEDIATRICS   07964   HENRY COUNTY RADIOLOGY	0 18, 969	1	1		194. 13 194. 14
	07965 HENRY COUNTY ANESTHESI OLOGY	0	Ö	13, 70,		194. 15
194. 16	07966 NEW CASTLE IMMEDICATE CARE & FAMILY	0	O			194. 16
200.00	1 1	0				200.00
201. 00 202. 00	9	6, 087, 507	0	1	ן ז	201. 00 202. 00
_02.00	, , , , , , , , , , , , , , , , , , ,	0,007,007	,	5,557,507	T.	1=32.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS HENRY COUNTY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0030

						5/18/2020 9:3	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	Cost Center Description	FIXT	EQUI P	BENEFITS	Reconciliation	& GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
		1.00	2.00	SALARI ES)	ΕΛ	F 00	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	4.00	5A	5. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	258, 852					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		272, 459				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 549	1, 549				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	35, 796	35, 796				5.00
7. 00 8. 00	OO7OO   OPERATION OF PLANT   OO8OO   LAUNDRY & LINEN SERVICE	68, 464 3, 421	68, 464 3, 421			4, 891, 609 485, 730	7. 00 8. 00
9. 00	00900 HOUSEKEEPING	1, 987	1, 987			1, 056, 065	9. 00
10.00	01000 DI ETARY	7, 218	7, 218			679, 105	•
11. 00	01100 CAFETERI A	1, 972	1, 972			355, 828	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	3, 964	3, 964			3, 281, 767	13.00
14. 00 15. 00	01400   CENTRAL SERVI CES & SUPPLY   01500   PHARMACY	7, 153 1, 562	7, 153 1, 562		0	1, 211, 072 3, 453, 430	1
	01600 MEDICAL RECORDS & LIBRARY	2, 755	2, 755			1, 142, 767	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	, ,	, ,		- 1	, , ,	
30. 00	03000 ADULTS & PEDI ATRI CS	29, 722	29, 722				30. 00
31.00	03100 INTENSIVE CARE UNIT	11, 601	11, 601			2, 201, 968	1
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	3, 068	3, 068	556, 888	0	913, 108	43. 00
50. 00	05000 OPERATING ROOM	16, 508	16, 508	4, 340, 735	O	5, 178, 045	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 559	1, 559			253, 385	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	11, 322	11, 322			3, 067, 705	1
57. 00	05700 CT SCAN	438	438			554, 769	1
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	535	535 0		0	344, 820 0	58. 00 59. 00
60.00	06000 LABORATORY	8, 261	8, 261	1, 929, 328		5, 080, 346	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	o	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	1, 736	1, 736			1, 054, 288	65. 00
66.00	06600 PHYSI CAL THERAPY	991	991			2, 260, 837	66. 00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	256 193	256 193			297, 506 129, 063	1
69. 00	06900 ELECTROCARDI OLOGY	173	0			421, 946	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	l o	0	0		1, 536, 278	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		5, 439, 211	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	-	0	73. 00
76. 00	03950 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS	711	711	119, 437	0	200, 095	76. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	3, 531, 318	ol	5, 513, 925	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	o	0			8, 544, 803	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89. 00
91.00	09100 EMERGENCY	10, 568	10, 568	2, 489, 606	0	4, 622, 437	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
101.00	10100 HOME HEALTH AGENCY	0	0	1, 072, 631	0	1, 791, 515	101.00
	SPECIAL PURPOSE COST CENTERS	-,				, , , , ,	
	11300   NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF		0	422 222		OOF 120	114.00
118.00	11600  HOSPICE   SUBTOTALS (SUM OF LINES 1 through 117)	233, 310	0 233, 310				•
110.00	NONREI MBURSABLE COST CENTERS	200, 010	200,010	12,001,000	10, 107, 021	70, 100, 007	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 009	0			21, 938	
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	1, 069, 453	0	2, 089, 228	1
	07950 HOSPI TALI ST	0	0	0	0		194. 00
	07951   RENTAL   07955   OTHER NONREI MBURSABLE COSTS		14, 616 0	0	_	116, 999 169, 011	•
	07956 DR AFZAL		0		Ö		194. 06
	07957 PHI LLI PS HALL	0	0	0	0		194. 07
	07958 OB DRS	0	0	0	0		194. 08
	07959 THE WATERS	24, 533	24, 533			1, 110, 426	
	07960 CAMBRIDGE CITY  07961 WELL BEING		0	428, 888 70, 401		789, 387 125, 500	
	07962 ACTIVATE HEALTH EMPLOYER CLINIC		0	70, 401		66, 122	
	07963 NEW CASTLE PEDIATRICS	0	0	0	o	0	194. 13
	07964 HENRY COUNTY RADI OLOGY	0	0	165, 884	0	1, 780, 132	
	07965 HENRY COUNTY ANESTHESI OLOGY	0	0	0	0		194. 15
200.00	07966 NEW CASTLE IMMEDICATE CARE & FAMILY Cross Foot Adjustments	ا	0	٥	"		194. 16 200. 00
201.00	1 1						201.00
		, 1		•	, ,		

Health Fir	nancial Systems HE	ENRY COUNTY MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS				Period: From 01/01/2019		
					To 12/31/2019	Date/Time Pre 5/18/2020 9:3	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS		(ACCUM. COST)	
		,		SALARI ES)			
		1.00	2. 00	4.00	5A	5. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	5, 628, 061	459, 446	16, 133, 323	3	16, 169, 824	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	21. 742389	1. 686294	0. 36212	5	0. 202849	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			36, 29	1	843, 388	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00081	5	0. 010580	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

		HENRY COUNTY MEN				Waster to D. 1	
COST ALLOC	ATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 01/01/2019 o 12/31/2019	Worksheet B-1 Date/Time Pre 5/18/2020 9:3	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERI A (FTE' S)	diii
		7. 00	8. 00	9.00	10.00	11. 00	
1.00 0010 2.00 0020 4.00 0040 5.00 0050 7.00 0070 8.00 0090 10.00 0100 11.00 0110 13.00 0130 14.00 0140 15.00 0150	ERAL SERVICE COST CENTERS  ON NEW CAP REL COSTS-BLDG & FIXT  ON NEW CAP REL COSTS-WYBLE EQUIP  ON EMPLOYEE BENEFITS DEPARTMENT  ON ADMINISTRATIVE & GENERAL  ON OPERATION OF PLANT  ON LAUNDRY & LINEN SERVICE  ON HOUSEKEEPING  ON DIETARY  ON OLAFETERIA  ON NURSING ADMINISTRATION  ON CENTRAL SERVICES & SUPPLY  ON PHARMACY  ON MEDICAL RECORDS & LIBRARY	215, 415 3, 421 1, 987 7, 218 1, 972 3, 964 7, 153 1, 562 2, 755	705, 361 29, 931 8, 039 0 0 0 0	5, 674 161 49 35 24	7, 644 0 0 0 0	308 25 8 0	13. 00 14. 00 15. 00
	ATIENT ROUTINE SERVICE COST CENTERS	2,755	,,	η 20	J 0	13	10.00
31. 00 0310 43. 00 0430	DO ADULTS & PEDIATRICS DO INTENSIVE CARE UNIT DO NURSERY	29, 722 11, 601 3, 068	32, 100	340	1, 476	56 16 6	31. 00
50. 00 0500 52. 00 0520 54. 00 0540 57. 00 0570 58. 00 0580 60. 00 0600 60. 01 0600 65. 00 0650	LLARY SERVICE COST CENTERS  OO OPERATING ROOM  OD DELIVERY ROOM & LABOR ROOM  OO RADIOLOGY-DIAGNOSTIC  OCT SCAN  OO MAGNETIC RESONANCE IMAGING (MRI)  OC CARDIAC CATHETERIZATION  OLABORATORY  OO RESPIRATORY  OO RESPIRATORY  OO PHYSICAL THERAPY	16, 508 1, 559 11, 322 438 535 0 8, 261 0 3, 315 25, 930	2, 953 51, 328 6 0 0 0 892 0 0	46 219 0 0 0 0 140 0	0 0 0 0 0	45 2 23 2 2 2 0 33 0 9	52. 00 54. 00 57. 00 58. 00 59. 00 60. 00 60. 01 65. 00
68. 00 0680 69. 00 0690 71. 00 0710 72. 00 0720 73. 00 0730 76. 00 0395 0UTF	OO OCCUPATIONAL THERAPY OO SPEECH PATHOLOGY OO ELECTROCARDIOLOGY OO MEDICAL SUPPLIES CHARGED TO PATIENTS OO IMPL. DEV. CHARGED TO PATIENT OO DRUGS CHARGED TO PATIENTS OO CARDIAC REHAB PATIENT SERVICE COST CENTERS	256 193 C C C C	0 0 0	0 26 0 0 0 0 0 0 0	0 0 0 0 0	3 1 2 0 0 0 2	68. 00 69. 00 71. 00 72. 00 73. 00 76. 00
88. 01 0880 89. 00 0890 91. 00 0910 92. 00 0920	OO RURAL HEALTH CLINIC DI RURAL HEALTH CLINIC II DO FEDERALLY QUALIFIED HEALTH CENTER DO EMERGENCY DO OBSERVATION BEDS (NON-DISTINCT PART) ER REIMBURSABLE COST CENTERS	15, 766 40, 753 C 10, 568	0 0	553 0	0	0 0 0 33	88. 01 89. 00
	DO HOME HEALTH AGENCY	2, 290	0	40	0	0	101. 00
113. 00 1130 114. 00 1140 116. 00 1160 118. 00	CIAL PURPOSE COST CENTERS  DO INTEREST EXPENSE  DO UTILIZATION REVIEW-SNF  DO HOSPICE  SUBTOTALS (SUM OF LINES 1 through 117  REIMBURSABLE COST CENTERS	2, 289 214, 406	l .	) 0 5, 186	0 7, 644		113. 00 114. 00 116. 00 118. 00
190. 00 1900 192. 00 1920 194. 00 0795 194. 01 0775 194. 05 0795 194. 06 0795 194. 08 0795 194. 09 0795 194. 10 0796 194. 11 0796 194. 12 0796 194. 13 0796 194. 14 0796 194. 15 0796	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN DO PHYSICIANS' PRIVATE OFFICES SO HOSPITALIST ST RENTAL ST OTHER NONREIMBURSABLE COSTS OF AFZAL FOR PHILLIPS HALL	1, 009 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	350 0 14, 936 0 5, 728 9, 465 123, 010 0 0 0 0 0 0 0	0 0 0 441 0 0 0 344 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. 730707			.,	,

Health Fina	ncial Systems H	ENRY COUNTY MEM	ORIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der Co	Provider CCN: 15-0030		Worksheet B-1	
					From 01/01/2019 To 12/31/2019		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(HOURS OF	(PATI ENT	(FTE' S)	
		(SQUARE	(POUNDS OF	SERVI CE)	DAYS)		
		FEET)	LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	1, 656, 752	111, 600	78, 15	235, 504	66, 090	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	7. 690978	0. 158217	13. 77352	30. 809001	214. 577922	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

		ENRY COUNTY MEMO		45 0000		u of Form CMS-2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provi der CC	Fr	eriod: com 01/01/2019	Worksheet B-1
				To	12/31/2019	Date/Time Prepared: 5/18/2020 9:36 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	
		(DI RECT	(COSTED		(TIME	
		NRSI NG HRS) 13.00	REQUI S. ) 14. 00	15. 00	SPENT) 16. 00	
	GENERAL SERVICE COST CENTERS DO100 NEW CAP REL COSTS-BLDG & FIXT	1				1.00
	00200 NEW CAP REL COSTS-BLDG & FIXT					1. 00 2. 00
	DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL					4. 00 5. 00
	00700 OPERATION OF PLANT					7. 00
	DO800 LAUNDRY & LINEN SERVICE					8. 00
	DO900  HOUSEKEEPI NG D1000  DI ETARY					9. 00 10. 00
	D1100 CAFETERI A	205				11. 00
	D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY	285	10, 269, 192			13. 00 14. 00
	D1500 PHARMACY	0	16, 840	100	2 070	15. 00
	D1600 MEDICAL RECORDS & LIBRARY  NPATIENT ROUTINE SERVICE COST CENTERS	0	15, 811	0	3, 878	16. 00
	03000 ADULTS & PEDIATRICS	56	194, 730	0	413	30.00
	D3100 INTENSIVE CARE UNIT D4300 NURSERY	16	86, 538 59, 493	0	220 154	31. 00 43. 00
P	ANCILLARY SERVICE COST CENTERS					
	D5000 OPERATING ROOM D5200 DELIVERY ROOM & LABOR ROOM	45	617, 007 15, 337	0	745 0	50. 00 52. 00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	O	194, 426	0	561	54. 00
	D5700 CT SCAN D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	79, 792 19, 426	0	205 39	57. 00 58. 00
59.00	D5900 CARDIAC CATHETERIZATION	0	0	0	O	59. 00
	D6000 LABORATORY D6001 BLOOD LABORATORY	0	1, 175, 707 0	0	595 0	60. 00 60. 01
65.00	D6500 RESPIRATORY THERAPY	0	31, 794	0	31	65. 00
	D6600 PHYSI CAL THERAPY D6700 OCCUPATI ONAL THERAPY	0	44, 120	0	24 3	66. 00 67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0	1	68. 00
	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	47, 132 1, 796, 479	0	32 71	69. 00 71. 00
	D7200 IMPL. DEV. CHARGED TO PATIENTS	0	5, 439, 211	0	109	71.00
	D7300 DRUGS CHARGED TO PATIENTS D3950 CARDIAC REHAB	0	0 3, 228	100 0	0 4	73. 00 76. 00
	OUTPATIENT SERVICE COST CENTERS			0	4	76.00
	D8800 RURAL HEALTH CLINIC D8801 RURAL HEALTH CLINIC II	53 72	40, 942 69, 385	0	34 54	88. 00 88. 01
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	04, 383	0	0	89. 00
	D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT PART)	33	274, 249	0	560	91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS					92.00
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	34, 817	0	15	101. 00
	11300 INTEREST EXPENSE					113. 00
	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE	0	12, 728	0	0	114. 00 116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	285	10, 269, 192	100	3, 878	118. 00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	ol	0	0	190. 00
192. 00 1	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192. 00
	07950 HOSPI TALI ST 07951 RENTAL	0	0	0	0	194. 00 194. 01
	07951 RENTAL 07955 OTHER NONREIMBURSABLE COSTS	0	0	0	0	194. 01
	07956 DR AFZAL 07957 PHILLIPS HALL	0	0	0	0	194. 06 194. 07
	07957 PHILETPS HALL 07958 OB DRS	0	0	0	0	194. 07
	07959 THE WATERS	0	0	0	0	194. 09
	D7960 CAMBRIDGE CITY D7961 WELL BEING	0	0	0	0	194. 10 194. 11
	07962 ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	194. 12
	D7963 NEW CASTLE PEDIATRICS D7964 HENRY COUNTY RADIOLOGY	0	0	0	0	194. 13 194. 14
194. 15	D7965 HENRY COUNTY ANESTHESI OLOGY	0	0	0	0	194. 15
194. 16 ( 200. 00	D7966 NEW CASTLE IMMEDICATE CARE & FAMILY Cross Foot Adjustments		O	0	O	194. 16 200. 00
201.00	Negative Cost Centers		4 /70 /	4 000 0==	4 404 05-	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	4, 104, 152	1, 670, 659	4, 209, 378	1, 481, 205	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	14, 400. 533333	0. 162687	42, 093. 780000	381. 950748	203. 00

Health Fina	ncial Systems F	IENRY COUNTY MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	NTION - STATISTICAL BASIS		Provi der CC		Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 5/18/2020 9:3	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY		
		(DI RECT	(COSTED		(TIME		
		NRSING HRS)	REQUIS.)		SPENT)		
		13. 00	14.00	15. 00	16. 00		
204.00	Cost to be allocated (per Wkst. B,	165, 648	237, 842	86, 11	4 102, 241		204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	581. 221053	0. 023161	861. 14000	26. 364363		205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						
,		·					

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 5/18/2020 9:3	pared: 6 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			5. 55			
30. 00 03000 ADULTS & PEDI ATRI CS	11, 146, 226		11, 146, 22	6 0	11, 146, 226	30. 00
31.00 03100 INTENSIVE CARE UNIT	3, 636, 302		3, 636, 30	2 0	3, 636, 302	31.00
43. 00 04300 NURSERY	1, 364, 095		1, 364, 09	5 0	1, 364, 095	43. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	8, 083, 197		8, 083, 19		8, 083, 197	50. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	395, 677		395, 67		395, 677	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	4, 383, 547		4, 383, 54	7 0	4, 383, 547	54.00
57.00  05700 CT SCAN	773, 753		773, 75	3 0	773, 753	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	450, 640		450, 64	0 0	450, 640	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0			0 0	0	59. 00
60. 00   06000   LABORATORY	6, 842, 194		6, 842, 19	4 0	6, 842, 194	60.00
60. 01   06001   BL00D   LABORATORY	0			0 0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	1, 424, 475	0	1, 424, 47		1, 424, 475	
66. 00  06600 PHYSI CAL THERAPY	3, 595, 156	0	3, 595, 15		3, 595, 156	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	384, 869	0	384, 86		384, 869	67. 00
68.00 06800 SPEECH PATHOLOGY	162, 499	0	162, 49	9 0	162, 499	
69. 00   06900   ELECTROCARDI OLOGY	536, 833		536, 83		536, 833	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 167, 293		2, 167, 29		2, 167, 293	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	7, 469, 066		7, 469, 06	6 0	7, 469, 066	•
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 209, 378		4, 209, 37		4, 209, 378	73. 00
76. 00 03950 CARDI AC REHAB	274, 743		274, 74	3 0	274, 743	76. 00
OUTPATIENT SERVICE COST CENTERS				.1		
88.00 08800 RURAL HEALTH CLINIC	7, 886, 633		7, 886, 63		7, 886, 633	•
88. 01   08801 RURAL HEALTH CLINIC II	12, 591, 853		12, 591, 85		12, 591, 853	1
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
91. 00   09100   EMERGENCY	6, 868, 142		6, 868, 14		6, 868, 142	1
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 664, 788		1, 664, 78	8	1, 664, 788	92. 00
OTHER REIMBURSABLE COST CENTERS	0.000.404		0.000.40	4	0.000.404	404 00
101. 00 10100 HOME HEALTH AGENCY	2, 238, 404		2, 238, 40	4	2, 238, 404	101.00
SPECIAL PURPOSE COST CENTERS  113. 00 11300   INTEREST EXPENSE						112 00
114.00 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
114.00 11400 011L1ZATTON REVIEW-SNF 116.00 11600 H0SPLCE	1 154 205		1 154 20	_	1, 156, 395	
200.00 Subtotal (see instructions)	1, 156, 395	0	1, 156, 39		89, 706, 158	
200.00   Subtotal (see Instructions) 201.00   Less Observation Beds	89, 706, 158 1, 664, 788	U	89, 706, 15 1, 664, 78		1, 664, 788	
202.00 Total (see instructions)	88, 041, 370	0				
202.00   10101 (See 111511 uctions)	00,041,370	U	00,041,37	어 어	00, 041, 370	1202.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0030 Peri od: Worksheet C From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

					0 12/31/2019	5/18/2020 9: 3	
			Title	XVIII	Hospi tal	PPS	<u> </u>
	·		Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'	·	·	+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	12, 760, 914		12, 760, 914			30. 00
31.00	03100 INTENSIVE CARE UNIT	5, 150, 156		5, 150, 156			31.00
43.00	04300 NURSERY	2, 335, 533		2, 335, 533	3		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	9, 713, 679	22, 300, 091			0.000000	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 155, 729	1, 183, 167	2, 338, 896	0. 169173	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 989, 033	17, 823, 279	19, 812, 312	0. 221254	0.000000	54.00
57.00	05700 CT SCAN	2, 328, 169	26, 624, 608	28, 952, 777	0. 026725	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	477, 305	7, 805, 364	8, 282, 669	0. 054408	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	0.000000	0.000000	59. 00
60.00	06000 LABORATORY	7, 943, 869	29, 477, 692	37, 421, 561	0. 182841	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	C	0.000000	0.000000	60. 01
65.00	06500 RESPI RATORY THERAPY	4, 061, 171	2, 582, 723	6, 643, 894	0. 214404	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	902, 353	4, 087, 693	4, 990, 046	0. 720466	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	194, 018	432, 979	626, 997	0. 613829	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	114, 470	191, 510	305, 980	0. 531077	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 448, 252	5, 277, 105	6, 725, 357	0. 079822	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 119, 655	10, 047, 963	15, 167, 618	0. 142889	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	15, 773, 774	7, 288, 479	23, 062, 253	0. 323865	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 496, 726	5, 696, 545	10, 193, 271	0. 412957	0.000000	73. 00
76.00	03950 CARDI AC REHAB	7, 187	750, 013	757, 200	0. 362841	0.000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	7, 178, 570	7, 178, 570			88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	11, 378, 764	11, 378, 764			88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C			89. 00
91.00	09100 EMERGENCY	4, 786, 575	39, 096, 209	43, 882, 784	0. 156511	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	325, 621	1, 964, 298	2, 289, 919	0. 727007	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	3, 222, 883	3, 222, 883	3		101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11600 HOSPI CE	0	1, 644, 651				116. 00
200.00		81, 084, 189	206, 054, 586	287, 138, 775	5		200. 00
201.00							201. 00
202.00	Total (see instructions)	81, 084, 189	206, 054, 586	287, 138, 775	5		202. 00

			To 12/31/2019	Date/Time Prepared: 5/18/2020 9:36 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00  03100   INTENSIVE CARE UNIT				31. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00   05000 OPERATING ROOM	0. 252491			50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 169173			52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 221254			54.00
57.00  05700 CT SCAN	0. 026725			57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 054408			58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00   06000   LABORATORY	0. 182841			60.00
60. 01   06001 BLOOD LABORATORY	0. 000000			60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 214404			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 720466			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 613829			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 531077			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 079822			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 142889			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 323865			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 412957			73. 00
76. 00   03950   CARDI AC   REHAB	0. 362841			76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88. 00
88.01 08801 RURAL HEALTH CLINIC II				88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
91. 00   09100   EMERGENCY	0. 156511			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 727007			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
114.00 11400 UTILIZATION REVIEW-SNF				114. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0030 Peri od: Worksheet C From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 5/18/2020 9:36 am Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 11, 146, 226 11, 146, 226 11, 146, 226 31.00 03100 INTENSIVE CARE UNIT 3, 636, 302 3, 636, 302 0 3, 636, 302 31.00 04300 NURSERY o 43.00 1, 364, 095 1, 364, 095 1, 364, 095 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 8.083.197 8.083.197 8, 083, 197 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 395, 677 395, 677 0 395, 677 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 383, 547 4, 383, 547 0 4, 383, 547 54.00 773, 753 773, 753 57 00 05700 CT SCAN 773. 753 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 450, 640 450, 640 450, 640 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 59.00 06000 LABORATORY 6, 842, 194 6, 842, 194 6, 842, 194 60.00 60.00 06001 BLOOD LABORATORY 60.01 Λ 60.01 65.00 06500 RESPIRATORY THERAPY 1, 424, 475 1, 424, 475 1, 424, 475 65.00 06600 PHYSI CAL THERAPY 3, 595, 156 3, 595, 156 66.00 3, 595, 156 0 0 0 0 0 66.00 06700 OCCUPATIONAL THERAPY 384.869 67 00 384 869 384, 869 67 00 68.00 06800 SPEECH PATHOLOGY 162, 499 162, 499 162, 499 68.00 69.00 06900 ELECTROCARDI OLOGY 536, 833 536, 833 536, 833 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 167, 293 2, 167, 293 2, 167, 293 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72 00 72 00 7, 469, 066 7, 469, 066 7, 469, 066 0 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 209, 378 4, 209, 378 4, 209, 378 73.00 03950 CARDI AC REHAB 76.00 274, 743 274, 743 0 274, 743 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 7,886,633 7,886,633 0 7, 886, 633 88.00 08801 RURAL HEALTH CLINIC II 12, 591, 853 12, 591, 853 0 12, 591, 853 88.01 88.01 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER o 89.00 0 6, 868, 142 91 00 09100 EMERGENCY 6, 868, 142 6, 868, 142 0 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1, 664, 788 1, 664, 788 1, 664, 788 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 2, 238, 404 2, 238, 404 2, 238, 404 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 1, 156, 395 116. 00 116. 00 11600 HOSPI CE 1, 156, 395 1, 156, 395 Subtotal (see instructions) 89, 706, 158 200. 00 89, 706, 158 200.00 0 89, 706, 158 0 201.00 Less Observation Beds 1, 664, 788 1, 664, 788 1, 664, 788 201. 00

88, 041, 370

88, 041, 370

88, 041, 370 202. 00

202.00

Total (see instructions)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2019 | Part | | Date/Time | Prepared: | 5/18/2020 9:36 am | Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0030

						5/18/2020 9:3	<u>6 am </u>
		_		e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•	•		
30.00	03000 ADULTS & PEDIATRICS	12, 760, 914		12, 760, 914	1		30.00
31.00	03100 INTENSIVE CARE UNIT	5, 150, 156		5, 150, 156			31.00
43.00	04300 NURSERY	2, 335, 533		2, 335, 533			43.00
Ţ	ANCILLARY SERVICE COST CENTERS	<u> </u>			<u>'</u>		
50.00	05000 OPERATING ROOM	9, 713, 679	22, 300, 091	32, 013, 770	0. 252491	0.000000	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 155, 729	1, 183, 167	2, 338, 896	0. 169173	0. 000000	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	1, 989, 033	17, 823, 279			0. 000000	
	05700 CT SCAN	2, 328, 169	26, 624, 608			0. 000000	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	477, 305	7, 805, 364			0. 000000	
	05900 CARDI AC CATHETERI ZATI ON	0	0,7000,00			0. 000000	
	06000 LABORATORY	7, 943, 869	29, 477, 692	37, 421, 56 <sup>-</sup>		0. 000000	
	06001 BLOOD LABORATORY	7,710,007	27, 177, 072		0.000000	0. 000000	
	06500 RESPIRATORY THERAPY	4, 061, 171	2, 582, 723			0. 000000	
	06600 PHYSI CAL THERAPY	902, 353	4, 087, 693			0. 000000	
	06700 OCCUPATI ONAL THERAPY	194, 018	432, 979			0.000000	
	06800 SPEECH PATHOLOGY	114, 470	191, 510			0. 000000	
	06900 ELECTROCARDI OLOGY	1, 448, 252	5, 277, 105			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 119, 655	10, 047, 963			0.000000	
	07/100 MEDICAL SUPPLIES CHARGED TO PATTENTS	1	7, 288, 479			0. 000000	
	07200 TMPL. DEV. CHARGED TO PATTENT	15, 773, 774				0.000000	
		4, 496, 726	5, 696, 545				
	03950 CARDI AC REHAB	7, 187	750, 013	757, 200	0. 362841	0. 000000	76. 00
	OUTPATIENT SERVICE COST CENTERS		7 170 570	7 170 57	1 000/2/	0.000000	00 00
	08800 RURAL HEALTH CLINIC	0	7, 178, 570			0.000000	
	08801 RURAL HEALTH CLINIC II	0	11, 378, 764			0. 000000	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1		0. 000000	
	09100 EMERGENCY	4, 786, 575	39, 096, 209			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	325, 621	1, 964, 298	2, 289, 919	0. 727007	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	0	3, 222, 883	3, 222, 883	3		101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11600 H0SPI CE	0	1, 644, 651				116. 00
200.00	Subtotal (see instructions)	81, 084, 189	206, 054, 586	287, 138, 77!	5		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	81, 084, 189	206, 054, 586	287, 138, 77!	5		202. 00
•		·					

			To 12/31/2019	Date/Time Prepared: 5/18/2020 9:36 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00   03100   INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00   05000   OPERATI NG ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
57.00   05700   CT   SCAN	0. 000000			57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 000000			59. 00
60. 00   06000   LABORATORY	0. 000000			60.00
60. 01   06001   BLOOD LABORATORY	0. 000000			60. 01
65. 00   06500   RESPI RATORY THERAPY	0. 000000			65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 000000			68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 00 03950 CARDI AC REHAB	0. 000000			76. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
88.01   08801   RURAL HEALTH CLINIC II	0. 000000			88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
91. 00   09100   EMERGENCY	0. 000000			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 I NTEREST EXPENSE				113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202. 00

Health Financial Systems	HENRY COUNTY MEN	MORIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2019 To 12/31/2019		narod:
				10 12/31/2019	5/18/2020 9: 3	6 am
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 291, 539	0	1, 291, 53	9 7, 251	178. 12	30.00
31.00 INTENSIVE CARE UNIT	461, 084		461, 08	4 1, 476	312. 39	31.00
43. 00 NURSERY	117, 988		117, 98	8 706	167. 12	43.00
200.00 Total (lines 30 through 199)	1, 870, 611		1, 870, 61	1 9, 433		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 349	418, 404				30.00
31.00 INTENSIVE CARE UNIT	626	195, 556	,			31.00
43. 00 NURSERY	C	0	)			43.00
200.00 Total (lines 30 through 199)	2, 975	613, 960	ı			200. 00

APPORTI ONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS   Provider CCN: 15-0030   Period: From 01/01/2019   Date/Time Prepared: 5/18/2020 9:36 am	Health Financial Systems	HENRY COUNTY MEN	MORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
Capital Related Cost   Capital Related	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	TAL COSTS	Provi der C		From 01/01/2019	Part II Date/Time Pre	pared: 6 am
Related Cost						PPS	
Column 4   Part II, col.   Col.   1 col.   Col.   Charges   Column 4   Part II, col.   20   20   3.00   4.00   5.00	Cost Center Description				t Inpatient		
Part II, col.   260   1.00   2.00   3.00   4.00   5.00							
ANCI LLARY SERVI CE COST CENTERS			· ·	1,	. Charges	column 4)	
NO   2.00   3.00   4.00   5.00   5.00		· ·	8)	2)			
ANCILLARY SERVICE COST CENTERS   50.00   05000   05PERATI IN GROOM   672,074   32,013,770   0.020993   3,346,563   70,254   50.00   52.00   05200   DELI VERY ROOM & LABOR ROOM   54,360   2,338,896   0.023242   5,586   130   52.00   52.00   05200   DELI VERY ROOM & LABOR ROOM   54,360   2,338,896   0.023242   5,586   130   52.00   54.00   05400   RADI OLOGY-DI AGNOSTI C   421,454   19,812,312   0.021272   1,149,566   24,454   54.00   57.00   0.05000   C. SCAN   27,328   28,952,777   0.000944   1,070,693   1,011   57.00   0.00000   0.00000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000							
50. 00         05000   OPERATI NG ROOM         672, 074   32, 013, 770   0.020993   3, 346, 563   70, 254   50. 00         50. 00         52. 00         52.00   05200   DELI VERY ROOM & LABOR ROOM   54, 360   2, 338, 896   0.023242   5, 586   130   52. 00         52. 00         52. 00   05200   DELI VERY ROOM & LABOR ROOM   54, 360   2, 338, 896   0.023242   5, 586   130   52. 00         52. 00         57. 00   05900   05900   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000		1. 00	2. 00	3. 00	4. 00	5. 00	
52.00         05200         DELI VERY ROOM & LABOR ROOM         54, 360         2, 338, 896         0.023242         5, 586         130         52.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         421, 454         19, 812, 312         0.021272         1, 149, 566         24, 454         54.00           57.00         05700         CT SCAN         27, 328         28, 952, 777         0.000944         1, 070, 693         1, 011         57.00           58.00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         22, 291         8, 282, 669         0.002691         166, 104         447         58.00           59.00         05900         CARDI AC CATHETERI ZATI ON         0         0.000000         0         0         59.00           60.01         06000         LABORATORY         364, 469         37, 421, 561         0.009740         3, 559, 041         34, 665         60.00           65.00         06500         RESPI RATORY THERAPY         83, 295         6, 643, 894         0.012537         1, 569, 750         19, 680         65.00           66.00         06600         PHYSI CAL THERAPY         262, 646         4, 990, 046         0.052634         392, 203         20, 643         66.00           67.							
54. 00         05400         RADI OLOGY-DI AGNOSTI C         421, 454         19, 812, 312         0.021272         1, 149, 566         24, 454         54. 00           57. 00         05700         CT SCAN         27, 328         28, 952, 777         0.000944         1,070, 693         1,011         57. 00           58. 00         05800         MAGNETI C RESONANCE IMAGING (MRI)         22, 291         8, 282, 669         0.002691         166, 104         447         58. 00           59. 00         05900         CARDI AC CATHETERI ZATION         0         0.000000         166, 104         447         58. 00         69. 00         0.000000         166, 104         447         58. 00         0.00000         0.000000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.00000         0         0.000000         0         0.00000         0         0.00000		•					
57. 00         05700   CT SCAN         27, 328   28, 952, 777   0.000944   1,070,693   1,011   57.00         1,011   57.00           58. 00         05800   MAGNETI C RESONANCE I MAGI NG (MRI )         22, 291   8, 282, 669   0.002691   166, 104   447   58.00           59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000		•		•			
58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI )         22, 291         8, 282, 669         0.002691         166, 104         447         58. 00           59. 00         05900         CARDI AC CATHETERI ZATI ON         0         0         0.000000         0         0.5900           60. 01         0600 LABORATORY         364, 469         37, 421, 561         0.00700         0.000000         0         0         0.000000           65. 00         06500 RESPI RATORY THERAPY         83, 295         6, 643, 894         0.012537         1, 569, 750         19, 680         65. 00           66. 00         06600 PHYSI CAL THERAPY         262, 646         4, 990, 046         0.052634         392, 203         20, 643         66. 00           67. 00         06700 OCCUPATI ONAL THERAPY         12, 994         626, 997         0.020724         90, 394         1, 873         67. 00           68. 00         08900 SPECCH PATHOLOGY         7, 682         305, 980         0.025106         58, 804         1, 476         68. 00           71. 00         07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         59, 734         15, 167, 618         0.003938         2, 061, 631         8, 119         71. 00           73. 00         07200 I MPL. DEV. CHARGED TO PATI ENT				•			
59. 00         05900         CARDI AC CATHETERI ZATI ON         0         0.000000         0.000000         0         59. 00           60. 00         06000         LABORATORY         364, 469         37, 421, 561         0.009740         3, 559, 041         34, 665         60. 00           65. 00         06500         BLOOD LABORATORY         0         0.000000         0         0         0.00           65. 00         06500         RESPI RATORY THERAPY         83, 295         6, 643, 894         0.012537         1, 569, 750         19, 680         65. 00           66. 00         06600         PHYSI CAL THERAPY         262, 646         4, 990, 046         0.052634         392, 203         20, 643         66. 00           67. 00         06700         OCCUPATI ONAL THERAPY         12, 994         626, 997         0.020724         90, 394         1, 873         67. 00           68. 00         OBSOS SPECH PATHOLOGY         7, 682         305, 980         0.025106         58, 804         1, 476         68. 00           69. 00         OF100         DELCTROCARDI OLOGY         7, 336         6, 725, 357         0.001091         870, 411         950         69. 00           71. 00         O7100         MEDI CAL SUPPLIES CHARGED TO PATI EN						-	
60. 00   06000   LABORATORY   364, 469   37, 421, 561   0.009740   3, 559, 041   34, 665   60. 00   60. 01   60. 01   BLOOD LABORATORY   0   0   0.000000   0   0   60. 01   65. 00   65. 00   RESPI RATORY THERAPY   83, 295   6, 643, 894   0.012537   1, 569, 750   19, 680   65. 00   660. 00   660. 00   67. 00   0.000000   0   0.000000   0   0.000000   0		22, 291	8, 282, 669				
60. 01 06001 BLOOD LABORATORY 0 0 0.000000 1 0 0 60. 01 65. 00 06500 RESPIRATORY THERAPY 83, 295 6, 643, 894 0.012537 1, 569, 750 19, 680 65. 00 66. 00 06600 PHYSI CAL THERAPY 262, 646 4, 990, 046 0.052634 392, 203 20, 643 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 12, 994 626, 997 0.020724 90, 394 1, 873 67. 00 68. 00 06800 SPEECH PATHOLOGY 7, 682 305, 980 0.025106 58, 804 1, 476 68. 00 06900 ELECTROCARDI OLOGY 7, 336 6, 725, 357 0.001091 870, 411 950 69. 00 071.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 59, 734 15, 167, 618 0.003938 2, 061, 631 8, 119 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 59, 734 15, 167, 618 0.003938 2, 061, 631 8, 119 71. 00 07300 DRUGS CHARGED TO PATI ENTS 86, 114 10, 193, 271 0.008448 2, 525, 076 21, 332 73. 00 07300 DRUGS CHARGED TO PATI ENTS 86, 114 10, 193, 271 0.008448 2, 525, 076 21, 332 73. 00 07300 DRUGS CHARGED TO PATI ENTS 86, 114 10, 193, 271 0.008448 2, 525, 076 21, 332 73. 00 00000 DUTPATI ENT SERVI CE COST CENTERS  88. 00 08800 RURAL HEALTH CLINI C 217, 921 7, 178, 570 0.030357 0 0 88. 01 08801 RURAL HEALTH CLINI C 11 461, 163 11, 378, 764 0.040528 0 0 0 88. 01 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0.000000 0 0 0 89. 00 91. 00 09100 EMERGENCY 453, 608 43, 882, 784 0.010337 1, 659, 328 17, 152 91. 00 92. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART) 192, 902 2, 289, 919 0.084240 98, 342 8, 284 92. 00		_	1			_	
65. 00		364, 469	37, 421, 561			· ·	
66. 00		_	1				
67. 00				1		· ·	
68. 00   06800   SPEECH PATHOLOGY   7, 682   305, 980   0. 025106   58, 804   1, 476   68. 00   69. 00   06900   ELECTROCARDI OLOGY   7, 336   6, 725, 357   0. 001091   870, 411   950   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   59, 734   15, 167, 618   0. 003938   2, 061, 631   8, 119   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENT   186, 397   23, 062, 253   0. 008082   6, 485, 054   52, 412   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   86, 114   10, 193, 271   0. 008448   2, 525, 076   21, 332   73. 00   07300   CARDI AC REHAB   20, 643   757, 200   0. 027262   0   0   76. 00   0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000		•					
69. 00   06900   ELECTROCARDI OLOGY   7, 336   6, 725, 357   0. 001091   870, 411   950   69. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   59, 734   15, 167, 618   0. 003938   2, 061, 631   8, 119   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENT   186, 397   23, 062, 253   0. 008082   6, 485, 054   52, 412   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   86, 114   10, 193, 271   0. 008448   2, 525, 076   21, 332   73. 00   07300   CARDI AC REHAB   20, 643   757, 200   0. 027262   0   0   0   76. 00   000000   0   0   0   0   0   0		12, 994	626, 997	0. 02072	90, 394	1, 873	67.00
71. 00		7, 682					
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   186, 397   23, 062, 253   0.008082   6, 485, 054   52, 412   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   86, 114   10, 193, 271   0.008448   2, 525, 076   21, 332   73. 00   76. 00   03950   CARDI AC REHAB   20, 643   757, 200   0.027262   0   0   0   76. 00   00000000000000000000000000000000	69. 00  06900 ELECTROCARDI OLOGY	7, 336	6, 725, 357	0. 00109	870, 411	950	69. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   86, 114   10, 193, 271   0.008448   2, 525, 076   21, 332   73. 00   76. 00   03950   CARDI AC REHAB   20, 643   757, 200   0.027262   0   0   0   76. 00   0000000   0   0   0   0   0   0		59, 734	15, 167, 618	0. 00393	2, 061, 631	8, 119	71. 00
76. 00 03950 CARDI AC REHAB 20, 643 757, 200 0.027262 0 0 0 76. 00 00000000000000000000000000	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	186, 397	23, 062, 253	0. 00808	6, 485, 054	52, 412	72. 00
S8. 00   OBSERVATI ON BEDS (NON-DISTINCT PART)   OBSERVATION BEDS (NON-DISTINCT PART)   OBSERVATION BEDS (NON-DISTINCT PART)   OBSERVATION BEDS (NON-DISTINCT PART)   OBSERVATION BEDS (NON-DISTINCT PART)   OUT   OUT	73.00 07300 DRUGS CHARGED TO PATIENTS	86, 114	10, 193, 271	0.00844	8 2, 525, 076	21, 332	73. 00
88. 00   08800   RURAL HEALTH CLINIC   217, 921   7, 178, 570   0.030357   0   0   88. 00   88. 01   89. 00   08801   RURAL HEALTH CLINIC II   461, 163   11, 378, 764   0.040528   0   0   88. 01   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0.000000   0   0   0.000000   0	76. 00 03950 CARDI AC REHAB	20, 643	757, 200	0. 02726	0	0	76. 00
88. 01   08801 RURAL HEALTH CLINIC II   461, 163   11, 378, 764   0.040528   0   0   0.040528   0   0.040528   0   0.040528   0   0.040528   0   0.040528   0   0.040528   0   0.040528   0   0.040528   0   0.040528   0   0.040528   0   0.040528   0   0.040528   0   0.040528   0   0.040528   0   0.040528   0   0   0.040528   0   0   0   0   0   0   0   0   0							
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0.000000   0   0   89. 00   91. 00   09100   EMERGENCY   453,608   43,882,784   0.010337   1,659,328   17,152   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   192,902   2,289,919   0.084240   98,342   8,284   92. 00	88.00  08800 RURAL HEALTH CLINIC	217, 921	7, 178, 570	0. 03035	57 0	0	88. 00
91. 00   09100   EMERGENCY   453,608   43,882,784   0.010337   1,659,328   17,152   91.00   92.00   09200   09SERVATI ON BEDS (NON-DI STI NCT PART)   192,902   2,289,919   0.084240   98,342   8,284   92.00	88.01  08801 RURAL HEALTH CLINIC II	461, 163	11, 378, 764	0. 04052	.8	0	88. 01
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 192, 902 2, 289, 919 0. 084240 98, 342 8, 284 92. 00	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0	0.00000	0 0	0	89. 00
		453, 608	43, 882, 784	0. 01033	1, 659, 328	17, 152	91.00
200.00   Total (lines 50 through 199)   3,614,411   262,024,638   25,108,546   282,882   200.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	192, 902	2, 289, 919	0. 08424	98, 342	8, 284	92.00
	200.00 Total (lines 50 through 199)	3, 614, 411	262, 024, 638	3	25, 108, 546	282, 882	200. 00

Health Financial Systems H	ENRY COUNTY MEM	IORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider C		Period: From 01/01/2019 To 12/31/2019		pared: 6 am
		Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown	•	Post-Stepdowr	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				•		
30. 00 03000 ADULTS & PEDIATRICS	0	О		0 0	0	30.00
31, 00 03100 INTENSIVE CARE UNIT	0	0		0	0	31. 00
43. 00   04300   NURSERY	0	0		0	0	
200.00 Total (lines 30 through 199)	0	ĺ		0	-	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
cost center bescription	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	Days	3 . 601 . 0)	l 11 Ogi alli bays	
		minus col. 4)				
	4.00	5.00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	7, 25	1 0.00	2, 349	30.00
31. 00   03100   NTENSI VE CARE UNI T		٥	1, 47		,	
43. 00   04300   NURSERY			70		020	
200.00 Total (lines 30 through 199)						200. 00
Cost Center Description	Inpati ent		7,43	3	2, 7/3	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	cost (cor. / x					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00   03100   NTENSI VE CARE UNI T						31.00
43. 00   03100  TNTENSTVE CARE UNIT						43.00
200.00 Total (lines 30 through 199)						200. 00
200.00   Total (Tries 30 through 199)	1					J200. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | Part IV | To | 12/31/2019 | Date/Time Prepared: | 5/18/2020 9:36 am | THROUGH COSTS

				XVIII	Hospi tal	PPS	
	Cost Center Description				Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00		0	0	(	0	0	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
54.00		0	0	(	0	0	54. 00
57.00	05700 CT SCAN	0	0	(	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (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 BLOOD LABORATORY	0	0	(	0	0	60. 01
65.00	06500 RESPI RATORY 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	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
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(	0	0	89. 00
91.00	09100 EMERGENCY	0	0		0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
200.00	Total (lines 50 through 199)	0	0	(	0	0	200. 00

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0030	Peri od:	Worksheet D
			From 01/01/2010	Dont IV

From 01/01/2019 To 12/31/2019 Part IV Date/Time Prepared: THROUGH COSTS 5/18/2020 9:36 am Title XVIII Hospi tal All Other Total Cost Ratio of Cost Cost Center Description Total Total Charges to Charges Medi cal (sum of cols. (from Wkst. C, Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) col s. 2, 3, 8) and 4) 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 32, 013, 770 0.000000 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 2, 338, 896 0.00000052.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 19, 812, 312 0.000000 54.00 54.00 57.00 05700 CT SCAN 0 28, 952, 777 0.000000 57.00 OI 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 8, 282, 669 0.000000 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 0.000000 59.00 60.00 06000 LABORATORY 37, 421, 561 0.000000 60.00 0 06001 BLOOD LABORATORY 0 0.000000 60 01 60 01 06500 RESPIRATORY THERAPY 0 0 65.00 6, 643, 894 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 4, 990, 046 0.000000 66.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 626, 997 67.00 06800 SPEECH PATHOLOGY 305, 980 0.000000 68 00 68 00 69.00 06900 ELECTROCARDI OLOGY 6, 725, 357 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 15, 167, 618 0.000000 71.00 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 23, 062, 253 0.000000 72.00 72 00 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 10, 193, 271 0.000000 73.00 76.00 03950 CARDI AC REHAB 0 757, 200 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 0 0 88 00 0 0 0 0 7, 178, 570 0.000000 88 00 08800 RURAL HEALTH CLINIC |08801|RURAL HEALTH CLINIC II 0 88. 01 0 11, 378, 764 0.000000 88.01 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 89.00 0 0 91. 00 09100 EMERGENCY 43, 882, 784 0.000000 91.00 0 92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) 2, 289, 919 0 0.000000 92.00 200.00 Total (lines 50 through 199) 262, 024, 638 200.00

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu o						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS			CN: 15-0030	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2019		
				To 12/31/2019	Date/Time Prep	pared:
					5/18/2020 9: 3	6 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	ŭ	Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11.00	12.00	13. 00	
ANCLLLARY SERVICE COST CENTERS	<u> </u>		•	•		

	Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		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	3, 346, 563		5, 838, 791	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	5, 586	0	0	0	52. 00
54. 00	05400  RADI OLOGY-DI AGNOSTI C	0. 000000	1, 149, 566	0	5, 301, 599	0	54. 00
57. 00	05700  CT SCAN	0. 000000	1, 070, 693	0	7, 067, 584	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	166, 104	0	2, 170, 687	0	58. 00
59. 00	05900   CARDI AC   CATHETERI ZATI ON	0. 000000	0	0	0	0	59. 00
60.00	06000 LABORATORY	0. 000000	3, 559, 041	0	2, 806, 788	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, 569, 750	0	373, 794	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	392, 203	0	34, 213	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	90, 394	0	6, 129	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	58, 804	0	3, 453	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	870, 411	0	2, 461, 271	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	2, 061, 631	0	1, 872, 348	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	6, 485, 054	0	3, 726, 609	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 525, 076	0	3, 739, 450	0	73. 00
76.00	03950 CARDI AC REHAB	0. 000000	0	0	291, 787	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000	0	0	0	0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0	0	89. 00
91.00	09100 EMERGENCY	0. 000000	1, 659, 328	0	8, 129, 905	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	98, 342	0	757, 276	0	92. 00
200.00	Total (lines 50 through 199)		25, 108, 546	0	44, 581, 684	0	200. 00

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	AL HOSPITAL In Lieu of Fo	
APPORTIONMENT OF MEDICAL.	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0030	Peri od:	Worksheet D

Health Financial Systems H	ENRY COUNTY MEN	10RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2019	Part V	
				To 12/31/2019		
		T: +1 o	: XVIII	Hospi tal	5/18/2020 9: 3 PPS	6 am
		l little	Charges	поѕрі таі	Costs	
Cost Center Description	Cost to Charge	DDS Doi mburcod		Cost	PPS Services	
cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
	Part I, col. 9		Subject To	Subject To		
	rait i, coi. 9		Ded. & Coins			
			(see inst.)	(see inst.)		
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50. 00   05000   OPERATING ROOM	0. 252491	5, 838, 791		0 0	1, 474, 242	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 169173			0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 221254			0	1, 173, 000	54.00
57. 00   05700   CT   SCAN	0. 026725			0 0	188, 881	
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0. 054408			0 0	118, 103	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			0	0	59.00
60. 00   06000   LABORATORY	0. 182841	2, 806, 788		o o	513, 196	60.00
60. 01   06001   BLOOD   LABORATORY	0. 000000			o o	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 214404	373, 794		0 0	80, 143	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 720466			0 0	24, 649	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 613829	6, 129		0 0	3, 762	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 531077	3, 453		0 0	1, 834	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 079822			0 0	196, 464	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 142889	1, 872, 348		0 0	267, 538	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 323865	3, 726, 609		0 0	1, 206, 918	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 412957	3, 739, 450		0 2, 143	1, 544, 232	73. 00
76. 00   03950   CARDI AC   REHAB	0. 362841	291, 787		0 0	105, 872	76. 00
OUTPATIENT SERVICE COST CENTERS	•					
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				0	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
91. 00   09100   EMERGENCY	0. 156511	8, 129, 905		0 0	1, 272, 420	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 727007			0 0	550, 545	92.00
200.00 Subtotal (see instructions)		44, 581, 684		0 2, 143	8, 721, 799	200. 00
201.00 Less PBP Clinic Lab. Services-Program				o o	ı	201. 00
Only Charges					ı	
202.00 Net Charges (line 200 - line 201)		44, 581, 684		0 2, 143	8, 721, 799	202. 00

				To 12/31/2019	Part V   Date/Time Pre   5/18/2020 9:3	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subj ect To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOUNT ARK OFFINIOR ORDER OFFITTERS	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS			I			
50. 00 05000 OPERATING ROOM	0	0	l .			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 I MAGING (MRI)	0	0				58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0				59. 00
60. 00   06000   LABORATORY	0	0				60.00
60. 01   06001   BLOOD LABORATORY	0	0				60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68.00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENT	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	885	•			73. 00
76. 00 03950 CARDI AC REHAB	0	0				76. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	0				88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
91. 00   09100   EMERGENCY	0	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	885				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00   Net Charges (line 200 - line 201)	0	885				202. 00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0030	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre 5/18/2020 9:3	pared:
	Title XVIII	Hospi tal	PPS	
Cost Contar Department on			•	

		Title XVIII	Hospi tal	5/18/2020 9: 3 PPS	6 am
	Cost Center Description		·	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	I NPATI ENT DAYS			7 051	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			7, 251 7, 251	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days,	0	3. 00
	do not complete this line.		-		
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room		21 of the cost	6, 168 0	4. 00 5. 00
3.00	reporting period	om days) thi dagii beecimber	31 01 116 6031	O	3.00
6. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7. 00
7.00	reporting period	dayo, tin oagii booomboi		· ·	,,,,,
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	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, 349	9. 00
	newborn days)	0			
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instructions)		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er			_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	Conly (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00
14.00	after December 31 of the cost reporting period (if calendar ye			0	14.00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	all (excluding swing-bed	lays)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17.00	SWING BED ADJUSTMENT	thurst December 21	T	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	0.00	19. 00
19.00	reporting period	s through becember 31 or	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	5)		11, 146, 226	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
23. 00	5 x line 17)   Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	noried (line 6	0	23. 00
23.00	x line 18)	31 of the cost reporting	g perrou (Trile o	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19)  Swing-bed cost applicable to NF type services after December 3	R1 of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or the cost reporting	perred (Trie 6	Ü	20.00
26. 00	Total swing-bed cost (see instructions)	(line 24 minus line 2/)		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		11, 146, 226	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	· Lino 29)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	F 1111e 20)		0.00000	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 min	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		<i>'</i>	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	•		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	ferential (line	11, 146, 226	37. 00
	27 minus line 36)		, ,		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	*		1, 537. 20	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		3, 610, 883	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	*		0 3, 610, 883	40.00
00	1.2.2 23. dai. 35.15. dapat. 5.1. 1 oditi 10 501 vi 50 505t (1116 57		ı	3, 310, 500	

	Financial Systems TATION OF INPATIENT OPERATING COST	HENRY COUNTY MEMO	Provider C		In Lie	wof Form CMS-2 Worksheet D-1	
- 0 0 1	2			10 0000	From 01/01/2019		
					To 12/31/2019	Date/Time Pre 5/18/2020 9:3	pared: 6 am
			_	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total	Average Per	9	Program Cost (col. 3 x col.	
		Impatrent costi	ilpati eiit bays	col. 2)	•	4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	0	0	0.	00 0	0	42. 00
43. 00	INTENSIVE CARE UNIT	3, 636, 302	1, 476	2, 463.	62 626	1, 542, 226	43. 00
44. 00	CORONARY CARE UNIT	0,000,002	., ., .	2, 100.1	52	1, 0.12, 220	44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00							46. 00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
						1. 00	
48. 00	Program inpatient ancillary service cost (W			_		6, 332, 793	
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(s	see instructio	ns)		11, 485, 902	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program in	npatient routine s	services (from	ı Wkst D sur	m of Parts L and	613, 960	50.00
00.00	III)	patront routino	30. 1. 000 (1. 0		or ranto r and	0.07,700	00.00
51. 00	Pass through costs applicable to Program in	patient ancillary	/ services (fr	om Wkst. D,	sum of Parts II	282, 882	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	: 50 and 51)				896, 842	52. 00
53. 00	Total Program inpatient operating cost excl		ated, non-phy	sician anestl	hetist, and	10, 589, 060	
	medical education costs (line 49 minus line				· 		
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION						   <sub> </sub>
	Program discharges Target amount per discharge					0 00	54. 00 55. 00
56. 00						l e	56. 00
57. 00		iting cost and tar	get amount (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	concerting noniced a	anding 1007	undoted and a	ampaundad by the	0	58. 00 59. 00
59. 00	Lesser of lines 53/54 or 55 from the cost r market basket	eporting period e	enarng 1996, t	ipuateu anu co	bilipounded by the	0.00	59.00
60. 00	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
61. 00						0	61. 00
	which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	r the target		
62. 00	Relief payment (see instructions)	, matractions,				0	62. 00
63. 00	Allowable Inpatient cost plus incentive pay	ment (see instruc	ctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine co	osts through Decem	nhar 31 of the	cost reporti	ing pariod (See	0	   64. 00
04.00	instructions)(title XVIII only)	313 thi ough becch	iber 31 of the	cost reporti	ing period (see	Ĭ	04.00
65. 00	Medicare swing-bed SNF inpatient routine co	sts after Decembe	er 31 of the c	ost reporting	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ino costs (lino 6	Manlus lino 4	.E) (+i +l o VVII	II only) For	0	66. 00
00. 00	CAH (see instructions)	THE COSTS (TITLE C	54 prus rine c	o)(title xvi)	ii oniy). Toi	٥	00.00
67. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 c	of the cost re	eporting period	0	67. 00
/ O OO	(line 12 x line 19)	no costo often De	noombor 21 of	the cost res	anting paried		40.00
08. 00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after be	ecember 31 01	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	: 68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER				\ \ \		70.00
70. 00 71. 00	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service	,		•	)		70. 00 71. 00
72. 00			ne 70 . Tine	2)			72.00
73. 00	Medically necessary private room cost appli						73. 00
74.00	Total Program general inpatient routine ser				D		74.00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	COSTS (Trom W	orksneet B, I	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ l	ine 2)					76. 00
77. 00	Program capital -related costs (line 9 x lin						77. 00
78.00	,		sovi don rocono	le)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem lim	•			,		81. 00
82.00	Inpatient routine service cost limitation (	· . · · · · · · · · · · · · · · · · · ·					82.00
83. 00 84. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see i	•	S)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85.00
86. 00							86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PA						07.00
07 00		16. 1				1, 083	87.00
87. 00 88. 00	Total observation bed days (see instruction Adjusted general inpatient routine cost per	•	line 2)			1, 537. 20	

Health Financial Systems HE	ENRY COUNTY MEN	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2019 Fo 12/31/2019	Date/Time Prep 5/18/2020 9:30	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	COST					
90.00 Capital -related cost	1, 291, 539	11, 146, 226	0. 115872	1, 664, 788	192, 902	90.00
91.00 Nursing School cost	0	11, 146, 226	0.000000	1, 664, 788	0	91.00
92.00 Allied health cost	0	11, 146, 226	0.00000	1, 664, 788	0	92.00
93.00 All other Medical Education	0	11, 146, 226	0.000000	1, 664, 788	0	93. 00

Health Financial Systems	HENRY COUNTY MEMORI	In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0030	Peri od: From 01/01/2019	Worksheet D-1	
			To 12/31/2019	Date/Time Pre 5/18/2020 9:3	
		Title XIX	Hospi tal	Cost	
Cost Center Description					

		Title XIX	Hospi tal	Cost	o alli
	Cost Center Description			1. 00	
PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS			7, 251	
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)				1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day		vate room days.	7, 251 0	3. 00
	do not complete this line.	3			
4.00	Semi-private room days (excluding swing-bed and observation be		. 21 -6	6, 168	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	, daya) +brayab Dagambar	21 of the cost	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	r days) through becember	31 Of the Cost	U	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)			407	0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	187	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instruct			0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) arter	0	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e 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 after December 31 of the cost reporting period (if calendar ye			0	13. 00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			706	
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of 1	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	.)		11, 146, 226	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decembe		na period (line	11, 140, 220	22. 00
	5 x line 17)	·		-	
23. 00	Swing-bed cost applicable to SNF type services after December $x$ line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reportir	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		11, 146, 226	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	I and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3.17	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	· line 28)		0. 000000	31.00
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	ions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin		· · · · · · · · · · · · · · · · · · ·	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	•		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	11, 146, 226	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 537. 20	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			287, 456	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	` '		0 287, 456	40. 00 41. 00
00	1.2.2 25. dam gonor di Tipati ditti Toditi ilo doi vi de dost (Titile di		'	207, 100	

	Financial Systems FATION OF INPATIENT OPERATING COST	IENRY COUNTY MEN	ORIAL HOSPITAL		In Lie Period:	worksheet D-1	
COMPUI	ATTON OF INFATIENT OFERATING COST		FI OVI dei Ci		From 01/01/2019		
				To 12/31/201		9 Date/Time Prepare 5/18/2020 9:36 an	
	Cost Contar Decemintion	Total	Ti tl Total	e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Inpatient Days	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
				col . 2)		4)	
42 00	NURSERY (title V & XIX only)	1. 00 1, 364, 095	2.00	3. 00 1, 932. 1	4. 00 5 0	5. 00	42. 00
12. 00	Intensive Care Type Inpatient Hospital Units		700	1,702.1			12.00
43.00	INTENSIVE CARE UNIT	3, 636, 302	1, 476	2, 463. 6	2 0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					165, 940	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(	(see instructio	ons)		453, 396	49. 00
50. 00	Pass through costs applicable to Program in	patient routine	services (from	n Wkst. D, sum	of Parts I and	0	50.00
	[111)					_	
51. 00	Pass through costs applicable to Program inpand IV)	oatient ancillar	ry services (fr	om Wkst. D, s	um of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52. 00
53. 00	Total Program inpatient operating cost exclu		elated, non-phy	sician anesth	etist, and	0	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	54. 00
	Target amount per discharge Target amount (line 54 x line 55)					0.00	
56. 00 57. 00	, ,	ting cost and ta	arget amount (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	· ·			ŕ	0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period	ending 1996, u	ipdated and co	mpounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	odated by the m	narket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		ts (lines 54 x	60), or 1% of	the target		
62.00 Relief payment (see instructions)					0	62. 00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST					0	63.00	
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						0	64. 00
instructions)(title XVIII only)					_		
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65. 00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For					0	66. 00	
47.00	CAH (see instructions)	a costo through	Dogombor 21 o	ef the east re	norting noried		47.00
67. 00	Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	ie costs through	i becember 31 c	or the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	ne 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	. 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N						07.00
70.00	Skilled nursing facility/other nursing facil	,					70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ iine	2)			71. 00
73. 00	Medically necessary private room cost applic	cable to Program					73. 00
74. 00	Total Program general inpatient routine serv	•			مسيام مايسم		74.00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	e costs (from w	orksneet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00 78. 00
79. 00	00   Inpatient routine service cost (line 74 minus line 77) 00   Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81. 00 82. 00	Inpatient routine service cost per diem limi		1)				81. 00 82. 00
83. 00							83. 00
84. 00	4.00 Program inpatient ancillary services (see instructions)						84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
00.00	PART IV - COMPUTATION OF OBSERVATION BED PAS		Jugir 03)				33.00
87. 00	Total observation bed days (see instructions	5)	11 0			1, 083	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				1, 537. 20 1, 664, 788	
57.50	(36)		•			1, 554, 750	, 57.00

Health Financial Systems HE	ENRY COUNTY MEN	IORI AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019	Date/Time Prep 5/18/2020 9:30	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	1, 291, 539	11, 146, 226	0. 11587	1, 664, 788	192, 902	90.00
91.00 Nursing School cost	0	11, 146, 226	0.00000	1, 664, 788	0	91.00
92.00 Allied health cost	0	11, 146, 226	0.00000	1, 664, 788	0	92.00
93.00 All other Medical Education	0	11, 146, 226	0. 00000	1, 664, 788	0	93. 00

	cial Systems HENRY NCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0030	Peri od:	u of Form CMS-2 Worksheet D-3	
				From 01/01/2019 To 12/31/2019	Date/Time Pre 5/18/2020 9:3	
		Ti tl e	xVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
	·		To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	IENT ROUTINE SERVICE COST CENTERS					1
4	ADULTS & PEDI ATRI CS			3, 569, 177		30.00
	INTENSIVE CARE UNIT			1, 853, 768		31.00
	NURSERY					43.00
	LARY SERVICE COST CENTERS					
	OPERATING ROOM		0. 25249			
	DELIVERY ROOM & LABOR ROOM		0. 16917			
	RADI OLOGY-DI AGNOSTI C		0. 22125			
	CT SCAN		0. 02672			
	MAGNETIC RESONANCE IMAGING (MRI)		0. 05440			
	CARDI AC CATHETERI ZATI ON		0.00000		0	
	LABORATORY		0. 18284		650, 739	
	BLOOD LABORATORY		0.00000		0	
	RESPI RATORY THERAPY		0. 21440			
	PHYSI CAL THERAPY		0. 72046		282, 569	
	OCCUPATIONAL THERAPY		0. 61382		55, 486	
	SPEECH PATHOLOGY		0. 53107		31, 229	
	ELECTROCARDI OLOGY		0.07982		69, 478	
	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 14288		294, 584	
	I MPL. DEV. CHARGED TO PATIENT		0. 32386			
	DRUGS CHARGED TO PATIENTS		0. 41295			
	CARDI AC REHAB		0. 36284	+1  0	0	76. 00
	TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC		0.00000	10	^	88. 00
	RURAL HEALTH CLINIC		0. 00000 0. 00000		0	
	FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	1
91 00 08900			0.00000		_	

1, 659, 328 98, 342

25, 108, 546

25, 108, 546

0. 156511

0. 727007

259, 703 71, 495

6, 332, 793 200. 00

91.00

92. 00

201. 00

202. 00

91. 00 09100 EMERGENCY

200.00

201.00

202.00

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

Net charges (line 200 minus line 201)

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

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

Health Financial Systems HENRY COUNTY	MEMORIAL HOSPITAL		In Lio	u of Form CMS-2	0552 10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Pre	pared:
	T' 11	VIV		5/18/2020 9: 3	6 am
	ΙΙΤΙ	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges		Program Costs (col. 1 x col.	
			Charges	2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			164, 496		30. 00
31. 00   03100   NTENSI VE CARE UNI T			76, 276		31. 00
43. 00   04300   NURSERY			215, 161		43. 00
ANCI LLARY SERVI CE COST CENTERS			215, 101		43.00
50. 00   05000   OPERATING ROOM		0. 25249	1 180, 752	45, 638	50. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 16917		0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 22125		5, 612	54. 00
57. 00   05700 CT   SCAN		0. 02672	·	719	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 05440	·	481	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 00000		0	59. 00
60. 00 06000 LABORATORY		0. 18284		27, 198	60.00
60. 01   06001   BLOOD LABORATORY		0. 00000		0	60. 01
65. 00 06500 RESPIRATORY THERAPY		0. 21440		12, 452	65. 00
66. 00   06600   PHYSI CAL THERAPY		0. 72046	·	4, 177	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 61382		917	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 53107		349	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 07982		1, 256	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 14288		22, 408	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 32386	·	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 41295		33, 172	73. 00
76. 00   03950   CARDI AC REHAB		0. 36284	·	88	76. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		1. 09863	6 0	0	88. 00
88. 01   08801 RURAL HEALTH CLINIC II		1. 10661		0	88. 01
80 00 08000 EEDEDALLY OHALLELED HEALTH CENTED		0.00000		0	90 00

165, 940 200. 00

11, 473

73, 302

783, 040

783, 040

89. 00

91.00

92.00 0

201. 00

202. 00

0.000000

0. 156511

0. 727007

89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER

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

Net charges (line 200 minus line 201)

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

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

09100 EMERGENCY

91.00

200.00

201.00

202.00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN:	From 01/01	Worksheet E 1/2019 Part A 1/2019 Date/Time Prepared: 5/18/2020 9:36 am

			10 12/31/2019	5/18/2020 9: 3	
		Title XVIII	Hospi tal	PPS	
			-	1 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1. 00	DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring p	orior to October 1 (s	see	5, 279, 339	1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring o	on or after October	(see	1, 861, 938	1. 02
1. 03	<pre>instructions) DRG for federal specific operating payment for Model 4 BPCI for di</pre>	scharges occurring	orior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for di	scharges occurring (	on or after	0	1. 04
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)				2. 00
2.01	Outlier reconciliation amount			0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	1		0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see	instructions)		48, 018	2. 03
2.04	Outlier payments for discharges occurring on or after October 1 (s	see instructions)		0	2. 04
3.00	Managed Care Simulated Payments			0	3. 00
4.00	Bed days available divided by number of days in the cost reporting	g period (see instru	ctions)	44. 91	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most rec	cent cost reporting	period ending on	0. 00	5. 00
	or before 12/31/1996. (see instructions)				
6. 00	FTE count for allopathic and osteopathic programs that meet the cr new programs in accordance with 42 CFR 413.79(e)	riteria for an add-o	n to the cap for	0. 00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified under			0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 Clost report straddles July 1, 2011 then see instructions.	CFR §412.105(f)(1)(i	/)(B)(2) If the	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic	and osteopathic prod	arams for	0. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)				
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots u	under 8 5503 of the	ACA If the cost	0.00	8. 01
	report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap slots funder § 5506 of ACA. (see instructions)	rom a closed teachi	ng hospi tal	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8	3, 8,01 and 8,02) (s	see	0.00	9. 00
10. 00	<pre>instructions) FTE count for allopathic and osteopathic programs in the current y</pre>	vear from vour record	ds	0.00	10.00
11. 00	FTE count for residents in dental and podiatric programs.	,			11. 00
12. 00	Current year allowable FTE (see instructions)			0. 00	
13. 00	Total allowable FTE count for the prior year.			0. 00	
14. 00	Total allowable FTE count for the penultimate year if that year er	nded on or after Sep	ember 30, 1997,	0.00	14. 00
	otherwise enter zero.	·			
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16.00	Adjustment for residents in initial years of the program			0.00	16. 00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17. 00
18. 00	Adjusted rolling average FTE count			0. 00	18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	
20. 00	Prior year resident to bed ratio (see instructions)			0. 000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	21. 00
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01				0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of Number of additional allopathic and osteopathic IME FTE resident of		R 412. 105	0.00	23. 00
24. 00	(f)(1)(iv)(C).			0. 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 22 or line	24 (800	0.00	
23.00	instructions)	of Title 23 of Title	24 (See	0.00	25.00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0.000000	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 01
	Disproportionate Share Adjustment				
30. 00	Percentage of SSI recipient patient days to Medicare Part A patier	nt days (see instruc	i ons)	3. 97	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)			22. 59	
32. 00	Sum of lines 30 and 31			26. 56	
33. 00	Allowable disproportionate share percentage (see instructions)				33. 00
34.00	Disproportionate share adjustment (see instructions)			198, 707	34.00

	Financial Systems HENRY COUNTY MEMORATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Peri od: From 01/01/2019	u of Form CMS-2   Worksheet E   Part A	
			To 12/31/2019	Date/Time Prep 5/18/2020 9:30	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35.00	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 uncompensated care payment (If line 34 is zero, enterinstructions)	er zero on this line) (se	e 540, 863	476, 271	35. 02
35. 03	Pro rata share of the hospital uncompensated care payment amo	ount (see instructions)	404, 536	119, 718	35. 03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0		524, 254		36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges on Worksheet S-3, Part I excluding		0		40. 00
	652, 682, 683, 684 and 685 (see instructions)		_		
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 instructions)	683, 684 an 685. (see	0		41. 00
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-	-DRGs 652, 682, 683, 684	0		41. 01
42. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not quali	ify for adjustment)	0.00		42. 00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	,			43. 00
	instructions)	•			
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instructions	•	0.00		45. 00
46.00	Total additional payment (line 45 times line 44 times line 47	1. 01)	0		46. 00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, s	small rural bosnitals	7, 912, 256 9, 082, 552		47. 00 48. 00
46.00	only. (see instructions)	silari Turai Nospitars	9, 062, 552		46.00
				Amount	
49. 00	Total payment for inpatient operating costs (see instructions	e)		1. 00 8, 789, 978	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar	•		586, 287	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51. 00
52. 00	Direct graduate medical education payment (from Wkst. E-4, li	ine 49 see instructions).		0	52. 00
53. 00 54. 00	Nursing and Allied Health Managed Care payment			0	53. 00 54. 00
54. 00	Special add-on payments for new technologies Islet isolation add-on payment			0	54. 00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	69)		ő	55. 00
56.00	Cost of physicians' services in a teaching hospital (see intr	•		0	56.00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	0	57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	58. 00
59.00	Total (sum of amounts on lines 49 through 58) Primary payer payments			9, 376, 265	
60. 00 61. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		0 9, 376, 265	60. 00 61. 00
62. 00	Deductibles billed to program beneficiaries	3 11116 00)		886, 312	
63.00	Coinsurance billed to program beneficiaries			·	63. 00
	Allowable bad debts (see instructions)			53, 830	
64. 00	Adjusted reimbursable bad debts (see instructions)			34, 990	65. 00
64. 00 65. 00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		23, 183	
	Allowable bad debts for dual eligible beliefferalles (see fils			8, 524, 261	
65. 00 66. 00 67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			_	
65. 00 66. 00 67. 00 68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for			0	
65. 00 66. 00 67. 00 68. 00 69. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	69. 00
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	.(For SCH see instruction	s)	0	69. 00 70. 00
65. 00 66. 00 67. 00 68. 00 69. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).	.(For SCH see instruction	s)	0	69. 00
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst	.(For SCH see instruction	s)	0 0 0	69. 00 70. 00 70. 50
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	(For SCH see instruction: tration) adjustment (see	s)	0 0 0 0	69. 00 70. 00 70. 50 70. 87
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	(For SCH see instruction: tration) adjustment (see	s)	0 0 0 0 0 0	69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90
65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	(For SCH see instruction: tration) adjustment (see	s)	0 0 0 0 0 551 -3, 083	69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 91 70. 92	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration Demonstration payment adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	(For SCH see instruction: tration) adjustment (see	s)	0 0 0 0 0 551 -3, 083 0	69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92
65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	(For SCH see instruction: tration) adjustment (see	s)	0 0 0 0 0 551 -3, 083	69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93

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:	Worksheet E
		From 01/01/2019	

CALCUL	ATTON OF REIMBURSEMENT SETTLEMENT	Provider C		From 01/01/2019 To 12/31/2019	Part A Date/Time Pre 5/18/2020 9:3	pared: 6 am
		Titl∈	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0	2	1019	696, 307	70. 96
70 07	the corresponding federal year for the period prior to 10/1)	a column O	_	000	221 440	70.07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in		4	1020	321, 660	70. 97
70. 98	the corresponding federal year for the period ending on or af- Low Volume Payment-3	ter 10/1)			0	70. 98
	HAC adjustment amount (see instructions)				0	70. 98
	Amount due provider (line 67 minus lines 68 plus/minus lines 6	40 & 70)			9, 518, 350	1
	Sequestration adjustment (see instructions)	37 & 70)			190, 367	
	Demonstration payment adjustment amount after sequestration				0	1
	Interim payments				9, 292, 856	
73.00	Tentative settlement (for contractor use only)				7, 272, 030	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2 72 and			35, 127	1
7 1. 00	73)	L, 72, and			00, 127	/ 1. 00
75. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			140, 610	75.00
	CMS Pub. 15-2, chapter 1, §115.2				,	
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		•			1
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	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 instru	uctions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruc-	tions)			0	93.00
	The rate used to calculate the time value of money (see instru	uctions)			0.00	
95.00	Time value of money for operating expenses (see instructions)				0	1
96. 00	Time value of money for capital related expenses (see instruc	tions)			0	96. 00
				Prior to 10/1		
				1. 00	2. 00	
100.00	HSP Bonus Payment Amount			/F/ 400	004 004	1400 00
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			656, 488	221, 234	1100.00
	HVBP adjustment factor (see instructions)			1. 0020432057	0. 9964299598	101 00
	HVBP adjustment amount for HSP bonus payment (see instructions)	-)		1, 341		102.00
102.00	HRR Adjustment for HSP Bonus Payment	3)		1, 341	-170	1102.00
103 00	HRR adjustment factor (see instructions)			0. 9981	0. 9917	103 00
	HRR adjustment amount for HSP bonus payment (see instructions)	)		-1, 247		104. 00
101.00	Rural Community Hospital Demonstration Project (§410A Demonstr		ıstment	1,217	1,000	101.00
200.00	Is this the first year of the current 5-year demonstration pe	riod under t	the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
	Cost Reimbursement			<u>'</u>		Ī
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	e 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	t 5-year demonst	ration	
	peri od)					
	Medicare target amount					204.00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement					ļ
	Program reimbursement under the §410A Demonstration (see insti					207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	iine 59)				208.00
	Adjustment to Medicare IPPS payments (see instructions)					209. 00
	Reserved for future use					210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)					211. 00
212 02	Comparision of PPS versus Cost Reimbursement	211)				212 00
	Total adjustment to Medicare Part A IPPS payments (from line :	211)				212. 00
	Low-volume adjustment (see instructions)	ad cost ==: ==	hurcomon+\			213. 00
∠10.00	Net Medicare Part A IPPS adjustment (difference between PPS and (line 212 minus line 213) (see instructions)	iu cost rein	ibul Selliel11)			218. 00
	(Time 212 millius Time 210) (See Thisti deti Ons)			ı		1

| In Lieu of Form CMS-2552-10 | Period: Worksheet E | From 01/01/2019 | Part A Exhibit 4 | Date/Time Prepared: 5/18/2020 9:36 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0030

						12/31/201/	5/18/2020 9: 3	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1.00	DRG amounts other than outlier		1.00	2.00	3.00		0.00	1. 00
	payments	1.00		Ü	·			
1. 01	DRG amounts other than outlier payments for discharges	1. 01	5, 279, 339	0	5, 279, 339		5, 279, 339	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	1, 861, 938	0		1, 861, 938	1, 861, 938	1. 02
	occurring on or after October							
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	(		0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	(	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to	2. 03	48, 018	O	48, 018	3	48, 018	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	0	0		0	0	2. 03
3. 00	Operating outlier	2. 01	0	0	(	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	0	0	(	0	0	4. 00
	Indirect Medical Education Adj	ustment						
5. 00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see instructions)	22. 00	0	0	(	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	(	0	0	6. 01
	instructions) Indirect Medical Education Adj	etment for the	Add-on for Sec	ction 122 of t	he MMA			l
7. 00	IME payment adjustment factor	27.00	0. 000000	0. 000000		0. 000000		7.00
8. 00	(see instructions)  IME adjustment (see	28. 00	0. 000000	0. 000000	0.00000		0	8. 00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	(	0	0	
	for managed care (see instructions)							
	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	(	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	(	) O	0	9. 01
40	Disproportionate Share Adjustm							
10. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1113	0. 1113	0. 1113	0. 1113		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	198, 707	0	146, 898	51, 809	198, 707	11. 00
11. 01	Uncompensated care payments  Additional payment for high pe	36.00 rcentage of ESR	524,254 RD beneficiary o	0 di scharges	404, 536	119, 718	524, 254	11. 01
12. 00	Total ESRD additional payment	46.00	ol	0	(	0	0	12.00
	(see instructions)		]					
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	7, 912, 256 9, 082, 552	0	5, 878, 79° 6, 725, 250		7, 912, 256 9, 082, 552	
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	8, 789, 978	0	6, 513, 635	2, 276, 343	8, 789, 978	15. 00
16. 00	<pre>instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)</pre>	50. 00	586, 287	8, 304	-148, 444	726, 427	586, 287	16. 00

LOW VO	LUME CALCULATION EXHIBIT 4			Provi der CO		Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Exhibi Date/Time Pre 5/18/2020 9:3	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A		Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	<u> </u>	0	1.00	2. 00	3. 00	4. 00	5. 00	
17. 00	Special add-on payments for new technologies	54. 00	0	0		0 0	0	17. 00
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced	68. 00	0	0		0 0	0	17. 02
18. 00	devices for applicable MS-DRGs Capital outlier reconciliation	93. 00	0	0		0 0	0	18. 00
40.00	adjustment amount (see instructions)			0.004	, 0,5 40	4 0 000 770	0.07/.0/5	40.00
19. 00	SUBTOTAL	W/C 1 1:	(1)	8, 304	6, 365, 19	1 3, 002, 770	9, 376, 265	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	577, 992	0	-148, 44	4 726, 436		
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0	0	20. 01
21. 00	Capital DRG outlier payments	2. 00	8, 295	8, 304		0 -9	8, 295	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see	10. 00	0. 0000	0. 0000	0.000	0. 0000		24. 00
	instructions)							
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	586, 287	8, 304	-148, 44	4 726, 427	586, 287	26. 00
		W/S E, Part A						
		line	Part A)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 10939			27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			696, 30	7	696, 307	28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 97				321, 660	321, 660	29. 00
100. 00	Pt. A, line) Transfer low volume		Y					100. 00
	adjustments to Wkst. E, Pt. A.		.					

Provider CCN: 15-0030

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 01/01/2019 Part A Exhibit 5 Date/Time Prepared: 12/31/2019 5/18/2020 9:36 am Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 4.00 2.00 3. 00 0 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 5, 279, 339 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 1, 861, 938 7, 141, 277 7, 141, 277 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 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 O 2.01 **BPCI** 48, 018 2 02 Outlier payments for discharges occurring 2 03 0 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 48, 018 48,018 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 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 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1113 0.1113 0. 1113 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 198.707 198.707 198.707 11.00 0 instructions) 11.01 404, 536 119, 718 Uncompensated care payments 36 00 524, 254 524, 254 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 13 00 7, 912, 256 404, 536 7, 507, 720 7, 912, 256 Subtotal (see instructions) 13 00 14.00 Hospital specific payments (completed by SCH 48.00 9, 082, 552 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 8, 789, 978 404, 536 8, 385, 442 8, 789, 978 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 586, 287 438, 510 147, 777 586, 287 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 17.00 C 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 C 0 18.00 amount (see instructions) 19.00 SUBTOTAL 843.046 8, 533, 219 9, 376, 265 19. 00

al th Financial	Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
ODI TAL AGGULDE	O COMPLETION (	IAON DEDUCTION ON OUR ATLON EVALUELT E	D 1 1 0011 45 0000	n	

HOSPITAL ACQ	UNIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Exhibi Date/Time Pre 5/18/2020 9:3	pared
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20.00 Capi ta	al DRG other than outlier	1.00	577, 992	432, 30	6 145, 686	577, 992	20.
20. 01   Model	4 BPCI Capital DRG other than outlier	1. 01	0		o o	0	20.
21.00 Capi ta	al DRG outlier payments	2.00	8, 295	6, 20	4 2, 091	8, 295	21.
21. 01   Model	4 BPCI Capital DRG outlier payments	2. 01	0		o o	0	21.
	ect medical education percentage (see uctions)	5. 00	0. 0000	0. 000	0.0000		22.
	ect medical education adjustment (see uctions)	6. 00	0		0 0	0	23.
	able disproportionate share percentage instructions)	10. 00	0. 0000	0. 000	0.0000		24.
	oportionate share adjustment (see uctions)	11.00	0		0 0	0	25.
	prospective capital payments (see uctions)	12. 00	586, 287	438, 51	0 147, 777	586, 287	26.
·		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1.00	2. 00	3. 00	4. 00	
27. 00							27.
	olume adjustment prior to October 1	70. 96	696, 307	696, 30	7	696, 307	28.
	olume adjustment on or after October 1	70. 97	321, 660		321, 660	321, 660	29
	payment adjustment (see instructions)	70. 93	4, 139		0 4, 139	4, 139	30.
	payment adjustment for HSP bonus nt (see instructions)	70. 90	551	1, 34	1 -790	551	30
	djustment (see instructions)	70. 94	-25, 485		0 -25, 485	-25, 485	31.
	djustment for HSP bonus payment (see uctions)	70. 91	-3, 083	-1, 24	·		31
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3. 00	4. 00	
instru	eduction Program adjustment (see uctions)	70. 99			0 0	0	
	fer HAC Reduction Program adjustment to E, Pt. A.		N				100

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0030	Peri od: Worksheet E From 01/01/2019 Part B To 12/31/2019 Date/Time Prepared:

			10 12/31/2019	5/18/2020 9:3	pared:
		Title XVIII	Hospi tal	PPS	o am
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1	
1.00	Medical and other services (see instructions)	+:>		885	
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction OPPS payments	tions)		8, 721, 799 8, 331, 222	
4.00	Outlier payment (see instructions)			13, 688	1
4. 00	Outlier reconciliation amount (see instructions)			13,000	1
5. 00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	
6.00	Line 2 times line 5	01.0.0)		0	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	8.0
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200		0	9. 0
10.00	Organ acqui si ti ons			0	10.0
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			885	11.0
	COMPUTATION OF LESSER OF COST OR CHARGES				1
40.00	Reasonable charges				
	Ancillary service charges	(0)		2, 143	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	The 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			2, 143	14.0
15. 00	Aggregate amount actually collected from patients liable for patients and actually collected from patients liable for patients and actually collected from patients liable for patients.	navment for services on	a charge basis	0	15.0
16. 00	Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR §413.13(e		= g		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	•		0.000000	17. 0
18.00	Total customary charges (see instructions)			2, 143	18. 0
19. 00	Excess of customary charges over reasonable cost (complete onl	ly if line 18 exceeds li	ne 11) (see	1, 258	19. 0
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete onl	ly if line 11 exceeds li	ne 18) (see	0	20. 0
21 00	instructions)			005	21.0
21. 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			885	
	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	1
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	1 40 (1 0113)		8, 344, 910	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
25.00	Deductibles and coinsurance amounts (for CAH, see instructions	s)		0	25.0
26. 00	Deductibles and Coinsurance amounts relating to amount on line	e 24 (for CAH, see instr	uctions)	1, 571, 650	26. 0
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	plus the sum of lines 22	and 23] (see	6, 774, 145	27. 0
	instructions)			_	
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ine 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	1
31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			6, 774, 145 856	1
32. 00	Subtotal (line 30 minus line 31)			6, 773, 289	
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CFS)		0,770,207	02.0
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.0
34.00	Allowable bad debts (see instructions)			292, 572	34.0
35.00	Adjusted reimbursable bad debts (see instructions)			190, 172	35.0
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		264, 935	
	Subtotal (see instructions)			6, 963, 461	
38. 00	MSP-LCC reconciliation amount from PS&R			-100	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39. 5
39. 97	Demonstration payment adjustment amount before sequestration	and daylone (one impty)	+:)	0	1
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	ced devices (see instruc	tions)	0	
40.00	Subtotal (see instructions)			6, 963, 561	1
40. 00	Sequestration adjustment (see instructions)			139, 271	
40. 02	Demonstration payment adjustment amount after sequestration			0	l
	Interim payments			6, 807, 594	
42. 00	Tentative settlement (for contractors use only)			0	
43.00	Balance due provider/program (see instructions)			16, 696	43.0
44.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	0	1
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	1
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94.0

In Lieu of Form CMS-2552-10

Period: Worksheet E-1
From 01/01/2019 Part I
To 12/31/2019 Date/Time Prepared:
5/18/2020 9:36 am Health Financial Systems HENRY OF ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 15-0030

					5/18/2020 9: 36	5 am
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt 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		9, 292, 85		6, 637, 933	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
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER			0 12/31/2019	130, 461	3. 01
3.02				0 08/13/2019	39, 200	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				0	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	169, 661	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		9, 292, 85	6	6, 807, 594	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR					F 00
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER			ol	0	5. 01
5. 01	TENTATIVE TO PROVIDER			0		5. 02
5. 02				0		5. 02
5.05	Provider to Program		l	0		3. 03
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51	TENTITIE TO TROOM III			o	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
0. , ,	5. 50-5. 98)					0. , ,
6.00	Determined net settlement amount (balance due) based on					6. 00
00	the cost report. (1)					00
6. 01	SETTLEMENT TO PROVIDER		35, 12	7	16, 696	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		9, 327, 98	3	6, 824, 290	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			)	1. 00	2.00	
8.00	Name of Contractor					8. 00
	· ·			•		

Heal th	Financial Systems HENRY COUNTY MEMOR	I AL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0030	Peri od:	Worksheet E-1	
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre 5/18/2020 9:3	
		Title XVIII	Hospi tal	PPS	o alli
		I tre xviii	HOSPI tai	FFS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	_
					A
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		14		1 00
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			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 l	ine 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
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	,			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31. 00
22.00	1 37	ing 21) (and instruction	5)		22.00

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

30. 00 31. 00 32. 00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-	10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0030	Peri od: Worksheet E-3 From 01/01/2019 Part VII To 12/31/2019 Date/Time Prepared	l:

The National Content   C				Γο 12/31/2019	Date/Time Pre 5/18/2020 9:3	
Inpatt ent			Title XIX	Hospi tal		<u> </u>
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
COMPUTATION OF NET COST OF COVERED SERVICES   1.00   1.0						
COMPUTATION OF NET COST OF COVERED SERVICES   1.00   1.0		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XIX	SERVICES		
Inpatient hospital/SNE/ME services						1
Medical and other services   0   2.00	1.00			453, 396		1.00
Organ acquisition (certified transplant centers only)					0	1
Subtotal (sum of lines 1, 2 and 3)				0		
Inpatient primary payer payments   0   5.00   5.00   0.000   0.0				453, 396	0	
0				0		
Subtotal (line 4 less sum of lines 5 and 6)					0	
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable Charges   Reasonable Charges   Routine service charges   783,040   0,00				453, 396	0	
Routine service charges		COMPUTATION OF LESSER OF COST OR CHARGES		<u> </u>		1
9.00   Ancillary service charges   783,040   0   9.00		Reasonable Charges				1
10.00   Organ acquisition charges, net of revenue   0   10.0	8.00	Routi ne servi ce charges		455, 933		8. 00
11.00   Incentive from target amount computation   11.00   12.00   1	9.00	Ancillary service charges		783, 040	0	9. 00
12. 00   Total reasonable charges (sum of 'lines 8 through 11)   12. 00   12. 00   13. 00   13. 00   13. 00   13. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   15. 00   14. 00   15. 00   14. 00   15. 00	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   13.00	12.00	Total reasonable charges (sum of lines 8 through 11)		1, 238, 973	0	12. 00
basis   14.00   Anounts 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)   1.00   1.000000   1.000000   1.000000   1.000000   1.000000   1.000000   1.000000   1.000000   1.000000   1.000000   1.000000   1.000000   1.000000   1.000000   1.000000   1.000000   1.000000   1.0000000   1.0000000   1.0000000   1.0000000   1.0000000   1.0000000000		CUSTOMARY CHARGES				
14. 00   Amounts that would have been realized from patients Liable for payment for services on a large basis had such payment been made in accordance with 42 CFR §413. 13(e)   0.000000   0.000000   15.00   1.238, 973   0.16.00   1.00   1.238, 973   0.16.00   1.00	13.00	Amount actually collected from patients liable for payment for	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 Total customary charges (see instructions)  17. 00 Excess of customary charges (see instructions)  18. 00 Excess of reasonable cost over reasonable cost (complete only if line 16 exceeds 1785.577 0 17. 00 17.						
15. 00	14. 00			0	0	14. 00
16.00   Total customary charges (see instructions)   1,238,973   0   16.00			2 CFR §413.13(e)			
17. 00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   785, 577   0   17. 00				1		
11		, , ,	1611			
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)   0   18.00   16) (see instructions)   0   0   19.00   17.00	17.00		y if line 16 exceeds	/85, 57/	0	17.00
16) (see instructions)	10 00		v if line 4 evenede line		0	10.00
19.00   Interns and Residents (see instructions)   0   0   19.00   20.00   2	18.00		y II ITHE 4 exceeds ITHE		U	18.00
20.00   Cost of physicians' services in a teaching hospital (see instructions)   0   20.00   21.00   20.00	10 00			0	0	10 00
21.00			uctions)	Ĭ	-	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				, , , , , , , , , , , , , , , , , , ,	-	
22. 00       Other than outlier payments       0       0       22. 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       26. 00         27. 00       Subtotal (sum of lines 22 through 26)       0       0       26. 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)       0       453, 396       0       29. 00         20. 00       Titles V or XIX (sum of lines 21 and 27)       0       453, 396       0       30. 00         31. 00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       453, 396       0       31. 00         32. 00       Deductibles       0       0       32. 00         33. 00       Coinsurance       0       0       33. 00         34. 00       All lowable bad debts (see instructions)       0       0       34. 00         35. 00       Utilization review       0<	21.00					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       0.26.00         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)       453,396       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)       453,396       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       35.00       0         36.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       453,396       0       36.00	22 00		compreted for the provide		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)       453,396       0         COMPUTATION OF REIMBURSEMENT SETTLEMENT         30.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       453,396       0       31.00         32.00       Deductibles       0       0       33.00         33.00       Coinsurance       0       0       33.00         34.00       Allowable bad debts (see instructions)       0       0       34.00         35.00       Utilization review       0       35.00         36.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       453,396       0       36.00         37.00       There ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       0       37.00         38.00       Direct graduate medical education payments (from Wkst. E-4)				-	-	
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)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  20.00 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  30.00 Coinsurance  31.00 Allowable bad debts (see instructions)  32.00 Utilization review  33.00 Utilization review  34.00 Allowable Tines 31, 34 and 35 minus sum of lines 32 and 33)  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)  453,396  453,					ŭ	
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)       453,396       0 29.00         COMPUTATION OF REIMBURSEMENT SETTLEMENT         30.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       453,396       0 30.00         31.00       Deductibles       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       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       36.00         38.00       Subtotal (line 36 ± line 37)       453,396       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)       453,396       0       453,396         40.00       Interim payments       585,787       0       41.				0		
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) 453, 396 0 29. 00  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 453, 396 0 31. 00 31. 00 Deductibles 0 0 0 32. 00 32. 00 Deductibles 0 0 0 33. 00 33. 00 Coinsurance 0 0 0 32. 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) 453, 396 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 453, 396 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) 453, 396 0 40. 00 41. 00 Interim payments 585, 787 0 41. 00 42. 00 Bal ance due provider/program (line 40 minus line 41) -132, 391 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0	26. 00			0	0	26, 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				0	0	27. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT   30.00   Excess of reasonable cost (from line 18)   0   30.00   31.00   Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   453,396   0   31.00   32.00   32.00   Coinsurance   0   0   32.00   33.00   Coinsurance   0   0   34.00   Allowable bad debts (see instructions)   0   0   34.00   35.00   Utilization review   0   35.00   35.00   Utilization review   0   35.00   36.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   453,396   0   36.00   37.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   0   37.00   38.00   Subtotal (line 36 ± line 37)   453,396   0   38.00   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   39.00   453,396   0   40.00   Interim payments   585,787   0   41.00   Interim payments   585,787   0   41.00   Balance due provider/program (line 40 minus line 41)   -132,391   0   42.00   43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   0   43.00	28.00			0	0	28. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT   30.00   Excess of reasonable cost (from line 18)   0   30.00   31.00   31.00   Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   453,396   0   31.00   32.00   Deductibles   0   0   0   32.00   33.00   Coinsurance   0   0   0   34.00   Allowable bad debts (see instructions)   0   0   34.00   35.00   Utilization review   0   35.00   36.00   37.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   0   37.00   38.00   Subtotal (line 36 ± line 37)   453,396   0   38.00   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   39.00   453,396   0   40.00   Interim payments   585,787   0   41.00   Interim payments   585,787   0   41.00   Balance due provider/program (line 40 minus line 41)   -132,391   0   42.00   43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   0   43.00	29.00	Titles V or XIX (sum of lines 21 and 27)		453, 396	0	29. 00
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)  453, 396  453, 396  0 31. 00  35. 00  37. 00  38. 00  39. 00  10 trect graduate medical education payments (from Wkst. E-4)  40. 00 Total amount payable to the provider (sum of lines 38 and 39)  453, 396  453, 396  0 36. 00  37. 00  38. 00  39. 00  453, 396  0 453, 396  0 453, 396  0 40. 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,		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) 453, 396 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 453, 396 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) 453, 396 0 40. 00 41. 00 Interim payments 585, 787 0 41. 00 42. 00 Balance due provider/program (line 40 minus line 41) -132, 391 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00	30.00	Excess of reasonable cost (from line 18)		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)   453, 396   0   36. 00   37. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   0   37. 00   38. 00   Subtotal (line 36 ± line 37)   453, 396   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)   453, 396   0   40. 00   41. 00   Interim payments   585, 787   0   41. 00   42. 00   Balance due provider/program (line 40 minus line 41)   -132, 391   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)		453, 396	0	31.00
34. 00   Allowable bad debts (see instructions)	32.00	Deducti bl es		0	0	32. 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) 453, 396 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 453, 396 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) 453, 396 0 40. 00 41. 00 Interim payments 585, 787 0 41. 00 42. 00 Balance due provider/program (line 40 minus line 41) -132, 391 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 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)  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 36.00  453,396  0 36.00  37.00  38.00  39.00  39.00  453,396  0 453,396  0 453,396  0 453,396  0 40.00  41.00 Interim payments  585,787  0 41.00  42.00	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)  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 37. 00  37. 00  37. 00  37. 00  37. 00  38. 00  39. 00  453, 396  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,  453,396  0 40.00  44.00  453,396  0 40.00  41.00  42.00  43.00	36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	453, 396	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,  39.00 453,396 585,787 0 41.00 42.00 43.00				0	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 42.00 43.00		,		453, 396	0	
41.00 Interim payments 585, 787 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -132, 391 0 42.00 43.00 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
chapter 1, §115.2	43.00		ce with CMS Pub 15-2,	0	0	43. 00
		cnapter 1, §115.2				I

Health Financial Systems

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

Provider CCN: 15-0030

oni y)				10 12/01/201/	5/18/2020 9: 3	6 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
4 00	CURRENT ASSETS	1 (45 544	Τ ,			1
1. 00 2. 00	Cash on hand in banks	1, 615, 541			0	
3.00	Temporary investments Notes receivable	0		-	0	
4. 00	Accounts receivable	16, 713, 194	1		0	
5. 00	Other recei vabl e	10, 713, 174		0	Ö	
6. 00	Allowances for uncollectible notes and accounts receivable				Ö	
7. 00	Inventory	761, 191	1	o o	Ö	
8.00	Prepaid expenses	1, 296, 938		0	0	
9.00	Other current assets	6, 402, 199	) (	0	0	9. 00
10.00	Due from other funds	66, 066, 490	)	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	92, 855, 553	(	0	0	11. 00
	FIXED ASSETS					1
12. 00	Land	46, 000	1			1
13.00	Land improvements	2, 117, 571	1	-	1	
14.00	Accumulated depreciation	-1, 522, 519	1	0		1
15.00	Buildings	41, 619, 768	1	0	0	
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-31, 410, 993 1, 115, 708	1		0	
18.00	Accumulated depreciation	-1, 082, 642	1	-	0	
19. 00	Fi xed equipment	18, 029, 130	1	1	0	
20. 00	Accumulated depreciation	-12, 604, 107	1		0	
21. 00	Automobiles and trucks	12,001,107	1		Ö	
22. 00	Accumulated depreciation	0	1	0 0	Ö	
23. 00	Major movable equipment	37, 295, 443		o o	Ō	
24.00	Accumul ated depreciation	-21, 627, 111	1	0	0	
25.00	Mi nor equi pment depreci abl e	0		0	0	25. 00
26.00	Accumulated depreciation	0	) (	0	0	26. 00
27.00	HIT designated Assets	0	) (	0	0	27. 00
28. 00	Accumulated depreciation	0	)	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	) (	0	0	
30.00	Total fixed assets (sum of lines 12-29)	31, 976, 248	3	0	0	30.00
	OTHER ASSETS					
31.00	Investments	11, 572, 692			1	
32.00	Deposits on Leases	0	1	0	1	
33.00	Due from owners/officers	7 (57 000	1	0	0	1
34. 00 35. 00	Other assets Tatal ather assets (sum of Lines 21 24)	7, 657, 980		1	0 0	
36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	19, 230, 672 144, 062, 473	1		l	
30.00	CURRENT LIABILITIES	144, 002, 473		0	0	30.00
37. 00	Accounts payable	2, 977, 083	(	0	0	37. 00
38. 00	Salaries, wages, and fees payable	5, 702, 733	1	o o	1	
39. 00	Payroll taxes payable	1	1	0	0	
40.00	Notes and Loans payable (short term)	1, 659, 497	' (	0	0	40.00
41.00	Deferred income	0	) (	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	43, 321, 285	5 (	0	0	43. 00
44.00	Other current liabilities	626, 189	1	0	ı	
45. 00	Total current liabilities (sum of lines 37 thru 44)	54, 286, 788	3	0	0	45. 00
	LONG TERM LIABILITIES	1	.1	J .		
46.00	Mortgage payable	0		٦	0	
47. 00	Notes payable	0	1	0		1
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	12, 951, 577		0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	12, 951, 577		-	l	
51. 00	Total liabilities (sum of lines 45 and 50)	67, 238, 365	1		l	
31.00	CAPITAL ACCOUNTS	07,230,303	1	<u>,                                     </u>		31.00
52.00	General fund balance	76, 824, 108	3			52. 00
53.00	Specific purpose fund		(			53.00
54.00	Donor created - endowment fund balance - restricted		1	0		54. 00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
EO 00	replacement, and expansion	74 004 400	,		_	E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	76, 824, 108		0	0	
00.00	[59]	144, 062, 473	Ί '			00.00
	1~./	I	1	1	I	ı

16.00

17.00

18.00

19.00

Health Financial Systems HENRY COUNTY MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-0030 Peri od: Worksheet G-1 From 01/01/2019 To 12/31/2019 Date/Time Prepared: 5/18/2020 9:36 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 Fund balances at beginning of period 1.00 71, 132, 144 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 5, 691, 961 2.00 Total (sum of line 1 and line 2) 76, 824, 105 3.00 0 3.00 4.00 Additions (credit adjustments) (specify) 0 0 0 0 0 4.00 0 5.00 0 5.00 6.00 6.00 7.00 0 0 0 0 7.00 8.00 8.00 0 9.00 9. 00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 76, 824, 105 11.00 11.00 Deductions (debit adjustments) (specify) 12.00 0 0 0 0 0 12.00 13.00 13.00 14.00 14.00 15.00 15.00

		6. 00	7. 00	8. 00	
1.00	Fund balances at beginning of period	0		0	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2. 00
3.00	Total (sum of line 1 and line 2)	0		0	3. 00
4.00	Additions (credit adjustments) (specify)		0		4. 00
5.00			0		5. 00
6.00			0		6. 00
7.00			0		7. 00
8.00			0		8. 00
9.00			0		9. 00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11. 00	Subtotal (line 3 plus line 10)	0		0	11. 00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13. 00
14.00			0		14. 00
15.00			0		15. 00
16.00			0		16. 00
17.00			0		17. 00
18.00	Total deductions (sum of lines 12-17)	0		0	18. 00
19.00	Fund balance at end of period per balance	0		0	19. 00

Endowment Fund

76, 824, 105

Plant Fund

16.00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

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

			To 12/31/2019	Date/Time Pre 5/18/2020 9:3	
	Cost Center Description	I npati ent	Outpati ent	Total	O dill
	South Season Per on	1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00	2.00	0.00	
	General Inpatient Routine Services				İ
1.00	Hospi tal	15, 096, 4	47	15, 096, 447	1.00
2.00	SUBPROVI DER - I PF	1,			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	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	15, 096, 4	47	15, 096, 447	10.00
	Intensive Care Type Inpatient Hospital Services	<u> </u>	•		
11. 00	INTENSIVE CARE UNIT	5, 150, 1	56	5, 150, 156	11. 00
12.00	CORONARY CARE UNIT				12. 00
13.00	BURN INTENSIVE CARE UNIT				13. 00
14.00	SURGICAL INTENSIVE CARE UNIT				14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of li	nes 5, 150, 1	56	5, 150, 156	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	20, 246, 6	03	20, 246, 603	17. 00
18.00	Ancillary services	55, 725, 3	90 141, 569, 211	197, 294, 601	18. 00
19. 00	Outpati ent servi ces	5, 112, 1	96 41, 060, 832	46, 173, 028	
20.00	RURAL HEALTH CLINIC		0 7, 178, 570		20. 00
20. 01	RURAL HEALTH CLINIC II		0 11, 378, 764	11, 378, 764	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY		3, 222, 883	3, 222, 883	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, 644, 651	1, 644, 651	
27. 00	NON-REI MBURSABLE	2, 8			
27. 01	PRO FEES		0 9, 053, 302	9, 053, 302	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 81, 087, 0	228, 086, 662	309, 173, 665	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		10/ 200 247		20.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		106, 208, 247		29. 00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32. 00 33. 00			0		32. 00 33. 00
34. 00			0		34.00
35. 00		ł	0		35.00
36. 00	Total additions (sum of lines 30-35)		0		36.00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00	DEDUCT (SI ECITI)		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)		<u> </u>		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(	transfer	106, 208, 247		43. 00
.5. 55	to Wkst. G-3, line 4)		.55, 255, 247		.5. 55
		•	•	•	•

	Financial Systems HENRY COUNTY MEMOR			u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-0030	Peri od: From 01/01/2019	Worksheet G-3	
			To 12/31/2019		nared:
			10 12,01,201,	5/18/2020 9: 30	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			309, 173, 665	1. 00
2.00	Less contractual allowances and discounts on patients' accoun	ts		204, 937, 675	2. 00
3.00	Net patient revenues (line 1 minus line 2)			104, 235, 990	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		106, 208, 247	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-1, 972, 257	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			1, 546, 544	1
8.00	Revenues from telephone and other miscellaneous communication	servi ces		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	1
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	1
15. 00	Revenue from rental of living quarters			0	
16. 00	Revenue from sale of medical and surgical supplies to other t	han patients		0	1
17. 00	Revenue from sale of drugs to other than patients			0	1
18. 00	Revenue from sale of medical records and abstracts			0	1 .0.00
19. 00	, , , , , , , , , , , , , , , , , , , ,			0	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	
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	INVESTMENT INCOME			5, 970, 064	24. 00

147, 610 24. 01 7, 664, 218 25. 00

5, 691, 961 26. 00

0

0 28.00 5,691,961 29.00

27. 00

24. 01 OTHER NONOPERATING
25. 00 Total other income (sum of lines 6-24)

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)

26.00 Total (line 5 plus line 25)

27. 00 LOSS ON SALE OF EQUIPMENT

23. 30	rerelledici ile	1	l ol	U	l ol	٧Į	V) 4	23. 30
24. 00	Total (sum of lines 1-23)	1, 072, 631	0	81, 793	0	275, 829	1, 430, 253	24. 00
		Recl assi fi cati	Recl assi fi ed	Adjustments	Net Expenses			
		on	Trial Balance		for Allocation			
			(col. 6 +		(col. 8 + col.			
			col . 7)		9)			
		7. 00	8. 00	9. 00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0	0	0	0			1.00
	Fi xtures							
2.00	Capital Related - Movable	0	0	0	0			2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0	0			3. 00
4.00	Transportation	0	0	0	0			4. 00
5.00	Administrative and General	-12, 023	467, 561	-15, 142	452, 419			5. 00
	HHA REIMBURSABLE SERVICES	1 0	505 070		505 070			
6.00	Skilled Nursing Care	0	,	0	000,,,0			6. 00
7.00	Physical Therapy	0	/	0	287, 462			7. 00
8.00	Occupational Therapy	0	48, 581	0	48, 581			8. 00
9.00	Speech Pathology	0	2, 199	0	2, 199			9.00
10.00	Medical Social Services	0	0 440	0	0 140			10.00
	Home Heal th Ai de	0	26, 449	0	26, 449			11.00
	Supplies (see instructions)	0	0	0	0		I	12.00
	Drugs	0		0	0			13.00
14. 00	DME	0	0	0	0			14. 00
15 00	HHA NONREI MBURSABLE SERVI CES	1 0		0				15 00
	Home Dialysis Aide Services	0	- 1	0	-			15.00
	Respiratory Therapy	0	0	0	0			16.00
	Private Duty Nursing	0	0	0	0			17. 00
	Clinic	0	0	0	0			18.00
	Health Promotion Activities	0	0	0	0			19. 00
	Day Care Program	0	0	0	0			20. 00
	Home Delivered Meals Program	0	0	0	0			21. 00
	Homemaker Service	0	0	0	0			22. 00
	All Others (specify)	0	0	0	0			23. 00
	Telemedicine	0		15 142	1 402 000		•	23. 50
24. 00	Total (sum of lines 1-23)	-12, 023	1, 418, 230	-15, 142	1, 403, 088		-	24. 00

T A	LLOCATION - HHA GENERAL SERVICE	COST		Provi der Co	CN: 15-0030	Period: From 01/01/2019	Worksheet H-1 Part I	
				HHA CCN:	15-7430	To 12/31/2019	Date/Time Pre 5/18/2020 9:3	pare 6 am
						Home Health Agency I	PPS	
			Capital Rela	ated Costs				
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance		Subtotal (cols. 0-4)	
	CENEDAL SERVICE COST CENTERS	0	1.00	2. 00	3. 00	4. 00	4A. 00	
00	GENERAL SERVICE COST CENTERS  Capital Related - Bldg. &	O	0				0	1.
	Fixtures							
00	Capital Related - Movable	0		0			0	2
0	Equipment Plant Operation & Maintenance		o	0		0	0	3
0	Transportation	Ö	ō	0		0 0	_	4
00	Administrative and General	452, 419	0	0		0 0	452, 419	5
00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	585, 978	0	0		0 0	585, 978	6
0	Physical Therapy	287, 462	0	0			287, 462	
0	Occupational Therapy	48, 581	o	0		0 0	48, 581	8
0	Speech Pathology	2, 199	0	0		0 0	2, 199	
00	Medical Social Services Home Health Aide	26, 449	0	0			0 26, 449	
00	Supplies (see instructions)	20, 447	Ö	0			20, 447	l .
00	Drugs	O	ō	0		0	0	1 .
00	DME	0	0	0		0 0	0	14
00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	l ol	0	0		0 0	0	15
00	Respiratory Therapy		0	0			0	
00	Private Duty Nursing	0	o	0		0 0	0	1
00	Clinic	0	0	0		0 0	0	
00	Health Promotion Activities Day Care Program	0	0	0			0	1
00	Home Delivered Meals Program		ol ol	0			0	
00	Homemaker Service	Ö	ō	0		0 0	0	
00	All Others (specify)	0	0	0		0 0	0	1 -
50	Telemedicine Total (sum of lines 1-23)	1, 403, 088	0	0			0 1, 403, 088	
00	Trotal (Sam of Trines 1 20)	Admi ni strati ve				0 0	1, 100, 000	_
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5. 00	6.00					
0	Capital Related - Bldg. &							1
	Fixtures							
0	Capital Related - Movable							2
0	Equipment Plant Operation & Maintenance							3
00	Transportation							4
00	Administrative and General	452, 419						. 5
0	HHA REIMBURSABLE SERVICES Skilled Nursing Care	278, 865	864, 843					1
0	Physical Therapy	136, 802	424, 264					7
0	Occupational Therapy	23, 119	71, 700					8
0	Speech Pathology	1, 046	3, 245					10
00	Medical Social Services Home Health Aide	12, 587	0 39, 036					10
00	Supplies (see instructions)	0	0					12
00	Drugs	0	0					13
00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14
00	Home Dialysis Aide Services	l ol	0					15
00	Respiratory Therapy	Ö	О					16
00	Private Duty Nursing	0	0					17
00	Clinic	0	0					18
00	Health Promotion Activities Day Care Program	0	0					19
	Home Delivered Meals Program		0					21
		1						
	Homemaker Service	0	0					22
00 00 00	Homemaker Service All Others (specify) Telemedicine	0	0					23

	<u>Financial Systems</u> LLOCATION - HHA STATISTICAL BAS		ENRY COUNTY MEM	Provi der Co		Peri od:	worksheet H-1	1002 10
				HHA CCN:	15-7430	From 01/01/2019 To 12/31/2019		pared: 6 am
						Home Health	PPS	<u> </u>
					I	Agency I		
		Capital Rei	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportati	onReconciliation	Admi ni strati ve	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance (SQUARE FEET)			(ACCUM. COST)	
		1. 00	2.00	3. 00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	.,	2.00	0.00		0, 00	0.00	
1.00	Capital Related - Bldg. &	0				0		1. 00
	Fixtures							
2.00	Capital Related - Movable		0			0		2. 00
3. 00	Equi pment	_	0	0		0		3. 00
4. 00	Plant Operation & Maintenance Transportation (see	0	0	0	•			4.00
4.00	instructions)	0	0	U		O		4.00
5. 00	Administrative and General	0	0	0		0 -452, 419	950, 669	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0		0 0	585, 978	6. 00
7.00	Physi cal Therapy	0	0	0		0 0	287, 462	7. 00
8.00	Occupational Therapy	0	0	0		0 0	48, 581	8. 00
9.00	Speech Pathology	0	0	0		0	2, 199	1
10.00	Medical Social Services	0	0	0		0	0	
11. 00	Home Health Aide	0	0	0		0 0	26, 449	•
12. 00	Supplies (see instructions)	0	0	0		0	0	
13.00	Drugs	0	0	0		0	0	
14. 00	DME	0	0	0		0 0	0	14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16. 00	Respiratory Therapy	0	0		l .		0	
17. 00	Private Duty Nursing	0	0	0			0	
18. 00	Clinic	0	0	0	1		0	
19. 00	Health Promotion Activities	0	0	0			0	
20.00	Day Care Program		0	0			0	20.00
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22. 00	Homemaker Service	0	0	0	•	0 0	0	22. 00
23. 00	All Others (specify)	0	0	Ö		0 0	0	
23. 50	Tel emedi ci ne	Ö	0	0		0 0	0	23. 50
24. 00	Total (sum of lines 1-23)	Ö	0	0		0 -452, 419	950, 669	
25. 00	Cost To Be Allocated (per	Ō	0	Ō		0	452, 419	
	Worksheet H-1, Part I)							
26 00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0.0000	00	0. 475895	26.00

HEARY ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 5/18/2020 9:36 am Provi der CCN: 15-0030 Peri od: From 01/01/2019 To 12/31/2019 HHA CCN: 15-7430 Home Health PPS

						Home Health Agency I	PPS	
			CAPITAL REL	ATED COSTS		rigency :		
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & 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 17. 00 18. 00 19. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	0 864, 843 424, 264 71, 700 3, 245 0 39, 036 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	4.00 388, 427 0 0 0 0 0 0 0 0 0 0 0 0 0	388, 427 864, 843 424, 264 71, 700 3, 245 0 39, 036 0 0 0 0 0 0 0 0 0 0 0 0	78, 792 175, 433 86, 062 14, 544 658 0 7, 918 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.  Cost Center Description	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DIETARY	0. 000000 CAFETERI A	NURSI NG ADMI NI STRATI ON	21. 00
1.00	Administrative and General	62, 549	8.00	9. 00 9, 540	10.00	11. 00	13.00	1.00
2. 00	Skilled Nursing Care	02, 349	0	9, 340	0	0	0	1
3.00	Physical Therapy	Ö	Ö	o	0	0	o o	3. 00
4.00	Occupational Therapy	0	0	0	0	0	0	4. 00
5.00	Speech Pathology	0	0	o	0	0	0	5. 00
6.00	Medical Social Services	0	0	0	0	0	0	6. 00
7.00	Home Health Aide	0	0	0	0	0	0	7. 00
8.00	Supplies (see instructions)	0	0	0	0	0	0	
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0	0	0	0	11. 00 12. 00
13. 00	Private Duty Nursing	0	0	Ö	0	0	o o	13. 00
14. 00	Clinic	Ō	0	0	0	0	o	14. 00
15.00	Health Promotion Activities	0	0	0	0	0	0	15. 00
16. 00	1 3	0	0	0	0	0	0	10.00
17. 00	9	0	0	0	0	0	0	
18. 00 19. 00	Homemaker Service All Others (specify)	0	0	0	0	0	0	18. 00 19. 00
19. 50	1 3/	0	0	0	0	0	0	19.50
20. 00 21. 00	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	62, 549	0	9, 540	0	0	0	20. 00 21. 00
	6 decimal places.							

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

Heal th	Financial Systems	HE	NRY COUNTY MEMOR	RIAL HOSPITAL		In Lie	eu of Form CMS-2	
ALLOCA	TION OF GENERAL SERVICE COSTS	TO HHA COST CENT	TERS	Provi der CO	CN: 15-0030	Peri od:	Worksheet H-2	
				HHA CCN:	15-7430	From 01/01/2019 To 12/31/2019	Date/Time Prep	pared:
							5/18/2020 9: 36	<u> </u>
						Home Health	PPS	
	C+ C+ D	CENTRAL	PHARMACY	MEDICAL	Cb. + - + - l	Agency I	Cultatata	
	Cost Center Description	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	Subtotal	Intern & Residents Cost	Subtotal	
		SUPPLY		LI BRARY		& Post		
		3011 21		LI DIVART		Stepdown		
						Adjustments		
		14. 00	15. 00	16. 00	24.00	25. 00	26.00	
1.00	Administrative and General	5, 664	0	5, 729			550, 701	1. 00
2.00	Skilled Nursing Care	0	0	0	,		1, 040, 276	
3.00	Physi cal Therapy	0	0	0			510, 326	
4.00	Occupational Therapy	0	0	0	,-		86, 244	
5.00	Speech Pathology		0	0	3, 9	03 0	3, 903	5. 00 6. 00
6. 00 7. 00	Medical Social Services Home Health Aide		0	0		-	46, 954	
8. 00	Supplies (see instructions)		0	0	1	0 0	0	8. 00
9. 00	Drugs		Ö	0		0 0	l ől	9. 00
10.00	DME	O	O	0		0 0	o	10.00
11.00	Home Dialysis Aide Services	o	O	0		0 0	o	11.00
12.00	Respi ratory Therapy	0	0	0		0 0	o	12.00
13.00	Private Duty Nursing	0	0	0		0 0	0	13.00
14. 00	Clinic	0	0	0		0 0	0	14. 00
15. 00	Health Promotion Activities	0	0	0	•	0 0	0	15. 00
16.00	Day Care Program	0	0	0		0 0	0	16.00
17.00	Home Delivered Meals Program Homemaker Service	0	0	0	•	0 0	0	17. 00 18. 00
18. 00 19. 00	All Others (specify)		0	0		0 0		19. 00
19. 50	Tel emedi ci ne		0	0		0 0		19. 50
20. 00	Total (sum of lines 1-19) (2)	5, 664	Ö	5, 729	2, 238, 4	-	2, 238, 404	
21. 00	Unit Cost Multiplier: column			-,	_,, .	- 1	_, _, _,	21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.  Cost Center Description	Allocated HHA	Total HHA					
	cost center bescription	A&G (see Part	Costs					
		11)	00313					
		27. 00	28. 00					
1.00	Administrative and General							1. 00
2.00	Skilled Nursing Care	339, 444	1, 379, 720					2.00
3.00	Physi cal Therapy	166, 520	676, 846					3.00
4.00	Occupational Therapy	28, 142	114, 386					4. 00
5.00	Speech Pathology	1, 274	5, 177					5. 00
6.00	Medical Social Services	0	(2.275					6. 00
7. 00 8. 00	Home Health Aide Supplies (see instructions)	15, 321	62, 275					7. 00 8. 00
9.00	Drugs		0					9. 00
10. 00	DME		0					10. 00
11. 00	Home Dialysis Aide Services		Ö					11. 00
12.00	Respiratory Therapy	o	o					12.00
13.00	Private Duty Nursing	o	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 19. 50	All Others (specify)	0	0					19. 00 19. 50
20. 00	Telemedicine Total (sum of lines 1-19) (2)	550, 701	2, 238, 404					19. 50 20. 00
21. 00	Unit Cost Multiplier: column	0. 326302	2, 230, 404					21. 00
00	26, line 1 divided by the sum	3. 020002						00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.						l	

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

Health Financial Systems	HENRY COUNTY MEMOR	HENRY COUNTY MEMORIAL HOSPITAL			
ALLOCATION OF GENERAL SERVICE CO BASIS	S TO HHA COST CENTERS STATISTICAL	Provi der CCN: 15-0030  HHA CCN: 15-7430	Peri od: From 01/01/2019 To 12/31/2019	Worksheet H-2 Part II Date/Time Prepared:	
		ППА ССN. 15-7430	10 12/31/2019	E/10/2020 0:24 am	

5/18/2020 9:36 am Home Health **PPS** Agency I CAPITAL RELATED COSTS NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliation ADMINISTRATIVE OPERATION OF Cost Center Description FLXT FOUL P **BENEFITS** & GENERAL PI ANT (SQUARE (SQUARE **DEPARTMENT** (ACCUM. (SQUARE FEET) FEET) (GROSS COST) FEET) SALARI ES) 1.00 2.00 5.00 7.00 5A 4.00 0 1.00 Administrative and General 0 1, 072, 631 0 388. 427 2, 290 1.00 0 2.00 Skilled Nursing Care 0 864, 843 2.00 3.00 Physical Therapy 0 0 424, 264 3.00 000000000000 Occupational Therapy 4.00 0 71.700 0 0 4.00 οĺ 0 5.00 Speech Pathology 3, 245 5.00 6.00 Medical Social Services 0 0 0 6.00 0 7.00 Home Health Aide 0 39, 036 7.00 0 0 Supplies (see instructions) 0 8.00 8.00 0 9.00 Drugs 0 0 0 9.00 10.00 DMF 0 10.00 0 0 11.00 Home Dialysis Aide Services 0 0 11.00 0 0 12.00 Respiratory Therapy 0 12.00 13.00 Private Duty Nursing 13.00 0 0 14.00 Clinic 0000000 0 0 14.00 0 0 15.00 Health Promotion Activities C 15.00 16.00 Day Care Program 16.00 17.00 Home Delivered Meals Program 0 0 17.00 0 0 0 Homemaker Service 18.00 18.00 0 0 19.00 All Others (specify) 19.00 19.50 Tel emedi ci ne 0 0 19.50 Total (sum of lines 1-19) 0 1, 072, 631 1, 791, 515 20.00 2, 290 20.00 21.00 Total cost to be allocated 388, 427 363, 407 62.549 21.00 0.000000 0. 362125 0. 202849 27. 313974 22.00 Unit cost multiplier 0.000000 22.00 Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL LINEN SERVICE (HOURS OF (PATI ENT (FTE'S) ADMINI STRATION SERVICES & (POUNDS OF SERVICE) DAYS) SUPPLY LAUNDRY) (COSTED (DI RECT NRSING HRS) REQUIS.) 10.00 8.00 9.00 11.00 13.00 14.00 1.00 Administrative and General 40 34, 817 1. 00 0 2.00 Skilled Nursing Care 0 0 0 0 0 0 0 0 0 0 2.00 00000000000000000 0 0 3 00 Physical Therapy 3 00 O 0 4.00 Occupational Therapy 0 4.00 5.00 Speech Pathology 0 5.00 0 6 00 Medical Social Services 0 0 6 00 O 0 7.00 Home Heal th Aide 0 7.00 8.00 Supplies (see instructions) 8.00 Drugs 0 0 9.00 0 0 0 0 0 0 0 0 0 0 9.00 0 0 10 00 10.00 DMF Ω Home Dialysis Aide Services 11.00 0 11.00 Respiratory Therapy 12.00 12.00 13.00 Private Duty Nursing 0 0 0 0 13.00 0 14.00 0 14.00 Clinic 15.00 Health Promotion Activities 0 0 15.00 Day Care Program 16.00 16.00 Home Delivered Meals Program 0 0 0 0 0 17.00 17.00 0 18.00 Homemaker Service C 18.00 0 19.00 All Others (specify) 0 0 19.00 19.50 Tel emedi ci ne 0 0 C 0 0 19.50

40

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238. 500000

C

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0.000000

20.00

21.00

34,817

5, 664

0. 162679 22. 00

0

0. 000000

20.00

21.00

22.00

Total (sum of lines 1-19)

Unit cost multiplier

Total cost to be allocated

	Financial Systems		NRY COUNTY MEMOR				u of Form CMS-	
	TION OF GENERAL SERVICE COSTS TO	O HHA COST CENT	ERS STATESTICAL	Provider CCN:	15-0030	Peri od: From 01/01/2019	Worksheet H-2   Part II	!
BASIS				HHA CCN:	15-7430	To 12/31/2019	Date/Time Pre	nared.
					.0 / .00	12, 01, 201,	5/18/2020 9: 3	
						Home Health	PPS	
						Agency I		
	Cost Center Description	PHARMACY	MEDI CAL					
		(COSTED	RECORDS &					
		REQUIS.)	LIBRARY					
			(TIME					
		45.00	SPENT)					-
1 00		15. 00	16. 00					1.00
1.00	Administrative and General	0	15					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physi cal Therapy	0	0					3. 00
4.00	Occupational Therapy	0	0					4. 00
5.00	Speech Pathology	0	0					5. 00
6.00	Medical Social Services	0	0					6. 00
7.00	Home Health Aide	0	0					7. 00
8.00	Supplies (see instructions)	0	0					8. 00
9. 00 10. 00	Drugs DME	0	0					9.00
		0	0					11. 00
11. 00 12. 00	Home Dialysis Aide Services	0	0					12.00
12.00	Respiratory Therapy Private 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						16. 00
17. 00	Home Delivered Meals Program	0						17. 00
18.00	Homemaker Service	0						18.00
19. 00	All Others (specify)	0	0					19.00
19. 00	Telemedicine	0	0					19. 50
20. 00	Total (sum of lines 1-19)	0	15					20.00
21. 00	Total cost to be allocated	0	5, 729					21. 00
	Unit cost nultiplier	0. 000000	381. 933333					22. 00

<b>PPORT</b>	IONMENT OF PATIENT SERVICE COST	S		Provi der C	CN: 15-0030	Peri od:	Worksheet H-3	2552-
				HHA CCN:	15-7430	From 01/01/2019 To 12/31/2019	Part I Date/Time Prep 5/18/2020 9:30	
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description		Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols. + 2)	1	Per Visit (col. 3 ÷ col.	
				Part II)		1.00	4)	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	1.00 PROGRAM COST A	2.00 GGREGATE OF TH	3.00 F PROGRAM LIN	4.00	5. 00	
	BENEFICIARY COST LIMITATION							
. 00	Cost Per Visit Computation Skilled Nursing Care	2.00	1, 379, 720		1, 379, 72	20 4, 466	308. 94	1. (
00	Physical Therapy	3.00		0	1		136. 05	
00	Occupational Therapy	4. 00		O			324. 04	
. 00	Speech Pathology	5. 00	5, 177	0	5, 17	77 50	103. 54	4.
. 00	Medical Social Services	6. 00				0 0	0. 00	
. 00	Home Heal th Ai de	7. 00			62, 2		70. 21	
00	Total (sum of lines 1-6)		2, 238, 404	0	2, 238, 40 Program Visi			7.
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject  Deductibles  Coinsurance	& Deductibles		
		0	1.00	2. 00	3.00	4. 00	5. 00	
	Limitation Cost Computation	I	I		ı			_
. 00 . 01	Skilled Nursing Care Skilled Nursing Care		17140 26900	0	1	6 8		8. 8.
. 01	Skilled Nursing Care		34620	0	1	39		8.
. 03	Skilled Nursing Care		99915	0	1			8.
. 00	Physi cal Therapy		17140	O	1	12		9.
. 01	Physi cal Therapy		26900	0	1	21		9.
. 02	Physi cal Therapy		34620	0	1	70		9.
. 03	Physical Therapy		99915	0				9.
0. 00 0. 01	Occupational Therapy Occupational Therapy		17140 26900	0		0 2		10. 10.
0. 02	Occupational Therapy		34620	0		0		10.
0. 03	Occupational Therapy		99915	0	15	-		10.
1. 00	Speech Pathology		17140	O	)	0		11.
1. 01	Speech Pathology		26900	0		0		11.
1. 02	Speech Pathology		34620	0		0		11.
1. 03	Speech Pathology Medical Social Services		99915 17140	0		39 0		11.
2. 00 2. 01	Medical Social Services		26900	0	1	0		12. 12.
2. 02	Medical Social Services		34620	0	1	0		12.
2. 03	Medical Social Services		99915	0	1	o		12.
3. 00	Home Health Aide		17140	O		O		13.
3. 01	Home Health Aide		26900	0	1	26		13.
	Home Health Aide		34620	0		16		13.
	Home Heal th Ai de		99915	0	1			13.
1. 00	Total (sum of lines 8-13)  Cost Center Description	From Wkst U 2	Facility Costs	Shared	4,62 Total HHA	Total Charges	Patio (col. 2	14.
	cost center bescription	Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
		0	1.00	Part II) 2.00	3. 00	4. 00	5. 00	
	Supplies and Drugs Cost Computa		1.00	2.00	3.00	4.00	5.00	

eal th	Financial Systems	Н	IENRY COUNTY MEMO	RIAL HOSPITAL		. In Lie	eu of Form CMS-2	2552-1
APPORT	IONMENT OF PATIENT SERVICE COSTS	S		Provi der CC	N: 15-0030	Period: From 01/01/2019	Worksheet H-3	
				HHA CCN:	15-7430	To 12/31/2019	Part I Date/Time Pre 5/18/2020 9:3	
				Ti tl e	XVIII	Home Health Agency I	PPS	o am
			Program Visits		Cost of	Agency I		
			Part	R	Servi ces	Part B		
	Cost Center Description	Part A	Not Subject to	Subject to Deductibles &	Part A	Not Subject to Deductibles &	Subject to Deductibles &	
				Coi nsurance		Coi nsurance	Coi nsurance	
	DART I COMPUTATION OF LEGIS	6.00	7.00	8.00	9.00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, AG	GREGATE OF THE	- PROGRAM LI	MITATION COST, OF	₹	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							1
. 00	Skilled Nursing Care	(	1, 974			0 609, 848		1.0
2. 00	Physical Therapy		2, 150			0 292, 508		2. 0
3. 00	Occupational Therapy		153			0 49, 578		3. 0
1.00	Speech Pathology		39			0 4, 038		4.0
5. 00	Medical Social Services					0 ., 555		5. 0
. 00	Home Heal th Aide		306			0 21, 484		6.0
7. 00	Total (sum of lines 1-6)		4, 622			0 977, 456		7. 0
. 00	Cost Center Description		4, 022			0 777,430		7.0
	cost center beserretron	6. 00	7.00	8. 00	9. 00	10.00	11. 00	
	Limitation Cost Computation	0.00	7.00	0.00	71.00	10.00	111.00	
3. 00	Skilled Nursing Care							8.0
3. 01	Skilled Nursing Care							8.0
. 02	Skilled Nursing Care							8.0
. 03	Skilled Nursing Care							8.0
. 00	Physical Therapy							9. 0
. 01	Physical Therapy							9.0
. 02	Physical Therapy							9.0
. 02	Physical Therapy							9.0
0. 00	Occupati onal Therapy							10.0
0. 01	Occupational Therapy							10.0
0. 01								10.0
	Occupational Therapy							
0.03	Occupational Therapy							10.0
1.00	Speech Pathology							11.0
1. 01	Speech Pathology							11.0
1. 02	, , , , , , , , , , , , , , , , , , , ,							11.0
1. 03	Speech Pathology							11.0
2. 00	Medical Social Services							12.0
2. 01	Medical Social Services							12. 0
2. 02	Medical Social Services							12. 0
2. 03	Medical Social Services							12. 0
3.00	Home Health Aide							13.0
3. 01	Home Health Aide							13. 0
3. 02	Home Health Aide							13.0
3. 03								13. 0
4.00	Total (sum of lines 8-13)							14. 0
		Prog	gram Covered Char	ges	Cost of			
					Servi ces			
				Б		D		
		ъ	Part		ь	Part B	6.1.	
	Cost Center Description	Part A	Not Subject to	Subject to	Part A	Not Subject to		
				Deductibles &		Deductibles &	Deductibles &	
		, , , , ,	Coi nsurance	Coi nsurance	0.00	Coi nsurance	Coi nsurance	
	Compliant and Day 2012	6. 00	7. 00	8. 00	9. 00	10.00	11.00	
IF 60	Supplies and Drugs Cost Computa		2 24 4	51		0 0	_	15 0
15.00		(	3, 814	0		0 0		
	Cost of Drugs		0	0		0	0	16.0

APPORT	IONMENT OF PATIENT SERVICE COST	TS .	Provider CCN: 15-0030	Peri od:	Worksheet H-3
			HHA CCN: 15-7430	From 01/01/2019 To 12/31/2019	Part I Date/Time Prepare 5/18/2020 9:36 am
			Title XVIII	Home Health	PPS
	Cost Center Description	Total Program		Agency I	
		Cost (sum of			
		col s. 9-10)			
		12. 00			
		OF AGGREGATE PROGRAM CO	OST, AGGREGATE OF THE PROGRAM LI	MITATION COST, OR	
	BENEFICIARY COST LIMITATION				
	Cost Per Visit Computation				
1.00	Skilled Nursing Care	609, 848			1.
2.00	Physical Therapy	292, 508			2.
3.00	Occupational Therapy	49, 578			3.
1.00	Speech Pathology	4, 038			4.
5. 00 5. 00	Medical Social Services Home Health Aide	1 "			5.
7. 00	Total (sum of lines 1-6)	21, 484 977, 456			0. 7.
. 00	Cost Center Description	911, 430			7.
	cost center bescription	12. 00			
	Limitation Cost Computation	12.00			
3. 00	Skilled Nursing Care				8.
3. 01	Skilled Nursing Care				8.
3. 02	Skilled Nursing Care				8.
3. 03	Skilled Nursing Care				8.
9. 00	Physi cal Therapy				9.
9. 01	Physical Therapy				9.
9. 02	Physi cal Therapy				9.
9. 03	Physical Therapy				9.
10. 00	Occupational Therapy				10.
10. 01	Occupational Therapy				10.
0. 02	Occupational Therapy				10.
0. 03	Occupational Therapy				10.
1.00	Speech Pathology				11.
11. 01	Speech Pathology				11.
1. 02	Speech Pathology Speech Pathology				11.
2. 00	Medical Social Services	1			12.
2. 00	Medical Social Services				12.
12. 01	Medical Social Services				12.
12. 02	Medical Social Services				12.
13. 00	Home Heal th Aide				13.
13. 01	Home Heal th Ai de				13.
13. 02	Home Heal th Ai de				13.
13. 03	Home Heal th Ai de				13.

Health Financial Systems	HE	NRY COUNTY MEM	ORIAL HOSPITAL	-	In Lie	2552-10	
APPORTIONMENT OF PATIENT SERVICE COST	S		Provi der C		Peri od:	Worksheet H-3	
			HHA CCN:	15-7430	From 01/01/2019 To 12/31/2019		
			Titl∈	XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to Charge		HHA Shared	Transfer to		
	Part I, col.	Rati o	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1. 00	2. 00	3.00	4. 00		
PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNISHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00 Physical Therapy	66. 00	0. 720466	0		0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67. 00	0. 613829	0		0 col. 2, line 3	. 00	2.00
3.00 Speech Pathology	68. 00	0. 531077	0		0 col. 2, line 4	. 00	3. 00
4.00 Cost of Medical Supplies	71. 00	0. 142889	O		0 col. 2, line 1	5. 00	4. 00
5.00   Cost of Drugs	73. 00	0. 412957	O		0 col. 2, line 1	6. 00	5. 00

_CULA	TION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	N: 15-0030	Peri od:	Worksheet H-4	
		HHA CCN:	15-7430	From 01/01/2019 To 12/31/2019		
		Title	XVIII	Home Health Agency I	PPS	
				Pa	rt B	
			Part A	Deductibles 8	Subject to Deductibles &	
		-	1. 00	Coi nsurance 2. 00	Coi nsurance 3.00	
F	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	DMARY CHARGES		2.00	3.00	
F	Reasonable Cost of Part A & Part B Services					
1	Reasonable cost of services (see instructions) Total charges				0 0	
	Customary Charges			-1		
	Amount actually collected from patients liable for payment fom on a charge basis (from your records)	servi ces		0	0	1
0	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in a			0	0 0	
	with 42 CFR §413. 13(b)	accor dance				
1	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000		1	
	Total customary charges (see instructions) Excess of total customary charges over total reasonable cost (	(complete		0	0 0 0	
	only if line 6 exceeds line 1)	(comprete			0	
	Excess of reasonable cost over customary charges (complete onl	yifline		0	0	
1	1 exceeds line 6) Primary payer amounts			0	0	,
0 1	Trindi y payor amounts			Part A	Part B	
				Servi ces	Servi ces	
F	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2. 00	+
	Total reasonable cost (see instructions)				0 0	1
	Total PPS Reimbursement - Full Episodes without Outliers				0 789, 824	
	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes				0 22, 826 0 10, 705	
- 1	Total PPS Reimbursement - PEP Episodes				0 691	
1	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0 4, 386	
	Total PPS Outlier Reimbursement - PEP Episodes				0	
	Total Other Payments				0	
	DME Payments Oxygen Payments				0 0 0	
- 1	Prosthetic and Orthotic Payments					
- 1	Part B deductibles billed to Medicare patients (exclude coinst	urance)			0	
	Subtotal (sum of lines 10 thru 20 minus line 21)				0 828, 432	2
- 1	Excess reasonable cost (from line 8)				0 0	
	Subtotal (line 22 minus line 23)				0 828, 432	
	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)				0 828, 432	
1	Reimbursable bad debts (from your records)				020, 432	2
	Reimbursable bad debts for dual eligible beneficiaries (see in	nstructions)				2
00	Total costs - current cost reporting period (line 26 plus line				0 828, 432	2
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	
1	Pioneer ACO demonstration payment adjustment (see instructions	5)			0	
1	Demonstration payment adjustment amount before sequestration Subtotal (see instructions)				0 0 828, 432	
4	Sequestration adjustment (see instructions)				0 828, 432	
1	Demonstration payment adjustment amount after sequestration				0 0	
- 1	Interim payments (see instructions)				0 811, 863	
	Tentative settlement (for contractor use only)				0	
00	Balance due provider/program (line 31 minus lines 31.01, 32, a Protested amounts (nonallowable cost report items) in accordan	,			0 1 0 0	
00						

15-0030 | Peri od: From 01/01/2019 | Worksheet H-5 15-7430 | To 12/31/2019 | Date/Time Prepared: 5/18/2020 9:36 am Provi der CCN: 15-0030 TO PROGRAM BENEFICIARIES HHA CCN:

					5/18/2020 9:36	6 am
				Home Health	PPS	
				Agency I		
		Inpatien	it Part A	Par	rt 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	811, 863	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,			0	0	2. 00
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					3.00
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	11 ogi alli to 11 ovi dei		I	0	T 0	3. 01
3. 02			1	0		3. 02
3. 02				0		3. 02
3. 04				0		3. 04
3. 05				0	0	3. 05
5.05	Provider to Program	L	L	O <sub>I</sub>		3.03
3.50	11 ovi del 12 e 11 ogi dili			0	0	3. 50
3. 51				0	l ol	3. 51
3. 52				O	l ol	3. 52
3. 53				O	l ol	3. 53
3.54				0	o	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	o	3. 99
	3, 50-3, 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)			0	811, 863	4. 00
	(transfer to Wkst. H-4, Part II, column as appropriate,					
	line 32)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	1	1			
5. 01				0	0	5. 01
5. 02				0	0	5. 02
5. 03				0	0	5. 03
5. 50	Provider to Program			ol	1 0	5. 50
5. 50				0		5. 50
5.51			•	0		5. 51
5. 5∠ 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 52 5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	1	6. 01
6. 02	SETTLEMENT TO PROGRAM			Ö	Ö	6. 02
7. 00	Total Medicare program liability (see instructions)			0	811, 864	7. 00
	(300 1101 401 610)			Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
8.00	Name of Contractor		0	1. 00	2. 00	8. 00
8. UU	Name of Contractor	I		I	1 1	8. UC

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS Provi der CCN: 15-0030 Peri od: Worksheet 0 From 01/01/2019 To 12/31/2019 Date/Time Prepared: 5/18/2020 9:36 am Hospi ce CCN: 15-1564

						3/10/2020 9.3	o am
		041.451.50	OTUER	loupzoza, ( )	Hospi ce I	OURTOTAL	
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 plus col. 2)	CATI ONS		
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	4, 770	4, 770	-4, 770	0	3.00
4. 00	ADMINISTRATIVE & GENERAL*	76, 752	279, 672		., , , , o	356, 424	4. 00
5. 00	PLANT OPERATION & MAINTENANCE*	0,752	53, 989		0	53, 989	5. 00
			23, 767	33, 969	0		
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	U	0	6. 00
7.00	HOUSEKEEPI NG*	0	0	0	0	0	7. 00
8.00	DI ETARY*	0	0	0	0	0	8. 00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	227	227	0	227	10.00
11.00	MEDI CAL RECORDS*	0	0	0	0	0	11.00
12. 00	STAFF TRANSPORTATION*	0	0		0	0	12.00
13. 00	VOLUNTEER SERVICE COORDINATION*		0		0	0	13.00
14. 00	PHARMACY*	0	4 244	4 244	0		14.00
		0	4, 244	4, 244	0	4, 244	1
15. 00	PHYSI CI AN ADMINI STRATI VE SERVI CES*	0	0	0	U	0	15.00
16. 00	OTHER GENERAL SERVI CE*	0	0	0	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	I NPATI ENT CARE-CONTRACTED**		6, 443	6, 443	0	6, 443	25. 00
26.00	PHYSI CI AN SERVI CES**	27, 301	0	27, 301	0	27, 301	26. 00
27.00	NURSE PRACTITIONER**	o	0	0	o	0	27. 00
28.00	REGISTERED NURSE**	258, 247	0	258, 247	o	258, 247	28. 00
29. 00	LPN/LVN**	0	0	0	0	0	29. 00
30. 00	PHYSI CAL THERAPY**	0	0	0	0	0	30.00
31. 00	OCCUPATIONAL THERAPY**	25	0	25	0	25	31.00
32. 00		25	0	25	0	25	32.00
	SPEECH/LANGUAGE PATHOLOGY**	25 250	0	25 250	0	25 250	1
33. 00	MEDICAL SOCIAL SERVICES**	35, 358	0	35, 358	0	35, 358	33. 00
34. 00	SPI RI TUAL COUNSELI NG**	0	0	0	0	0	34. 00
35. 00	DI ETARY COUNSELI NG**	0	0	0	0	0	35. 00
36. 00	COUNSELING - OTHER**	0	0	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	24, 539	0	24, 539	0	24, 539	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38. 00
39. 00	PATIENT TRANSPORTATION**	0	0	0	0	0	39. 00
40.00	I MAGI NG SERVI CES**	o	0	o	o	0	40.00
41. 00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0	0	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS**		0		0	0	42. 50
43. 00	OUTPATIENT SERVICES**		0		0	0	43.00
		0	0	0	0		1
44. 00	PALLIATIVE RADIATION THERAPY**	0	0	0	U	0	44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46. 00
	NONREI MBURSABLE COST CENTERS						
60. 00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
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*	ol	0	o	o	0	63. 00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
	OTHER PHYSI CI AN SERVI CES*	0	0	o	0	0	65. 00
66. 00	RESIDENTI AL CARE*		0	٥	0	0	66.00
67. 00			0		0	0	67.00
	ADVERTI SI NG*		0		o o		
68. 00	TELEHEALTH/TELEMONI TORI NG*		0	0	0	0	68. 00
	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		O	0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71. 00
100.00	TOTAL	422, 222	349, 345	771, 567	-4, 770	766, 797	100. 00
* Tran	sfer the amounts in column 7 to Wkst. 0-5, co	lumn 1 line as	annronri ate				

<sup>\*</sup> 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.

From 01/01/2019 To 12/31/2019 Date/Time Prepared: 5/18/2020 9:36 am Hospi ce CCN: 15-1564 Hospi ce I

				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*	-14, 555	-14, 555		3.00
4.00	ADMI NI STRATI VE & GENERAL*	0	356, 424		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	53, 989		5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6. 00
7.00	HOUSEKEEPI NG*	0	0		7. 00
8.00	DI ETARY*	0	0		8.00
9.00	NURSI NG ADMI NI STRATI ON*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	227		10.00
11. 00	MEDI CAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	4, 244		14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				17. 00
25 00	DIRECT PATIENT CARE SERVICE COST CENTERS		( 440		25.00
25. 00	INPATIENT CARE-CONTRACTED**	0	6, 443		25. 00
26. 00	PHYSI CI AN SERVI CES**	0	27, 301		26.00
27. 00	NURSE PRACTITIONER**	0	250 247		27. 00
28. 00	REGI STERED NURSE**	0	258, 247		28. 00
29. 00	LPN/LVN**	0	0		29.00
30. 00 31. 00	PHYSI CAL THERAPY**	0	0		30. 00 31. 00
31.00	OCCUPATIONAL THERAPY**	0	25		
	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33. 00 34. 00	MEDICAL SOCIAL SERVICES** SPIRITUAL COUNSELING**	0	35, 358		33.00
35.00	DI ETARY COUNSELING**	0	0		34. 00 35. 00
36. 00	COUNSELING - OTHER**	0	0		36.00
36.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0			37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	24, 539		38.00
39. 00	PATIENT TRANSPORTATION**	0	0		39.00
40. 00	IMAGING SERVICES**	0	0		40. 00
41. 00	LABS & DI AGNOSTI CS**	0	0		41. 00
41.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0		42.00
42. 00	DRUGS CHARGED TO PATIENTS**	0	0		42. 50
42. 50	OUTPATIENT SERVICES**	0	0		43. 00
44. 00	PALLIATIVE RADIATION THERAPY**	0	0		44. 00
45. 00	PALLIATIVE RADIATION THERAPT	0	0		45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46. 00
40.00	NONREI MBURSABLE COST CENTERS	l o	U		40.00
60. 00	BEREAVEMENT PROGRAM *	0	0		60.00
61. 00	VOLUNTEER PROGRAM *	0	0	l .	61.00
62.00	FUNDRAI SI NG*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*		0		63.00
64. 00	PALLIATIVE CARE PROGRAM*		0		64.00
65. 00	OTHER PHYSICIAN SERVICES*		0		65.00
66. 00	RESIDENTIAL CARE*		0		66.00
67.00	ADVERTI SI NG*		0		67.00
68.00	TELEHEALTH/TELEMONI TORI NG*		0		l l
	1				68. 00
69.00	THRIFT STORE*		0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	14 555	, and the second		71.00
100.00		-14, 555	752, 242		100. 00

<sup>\*</sup> 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.

Provi der CCN: 15-0030

Peri od: Worksheet 0-2 From 01/01/2019 To 12/31/2019

Date/Time Prepared: 5/18/2020 9:36 am Hospi ce CCN: 15-1564

					37 107 2020 7. 3	o am	
				Hospi ce I			
	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL		
			1 + col . 2)	CATI ONS			
	1.00	2.00	3. 00	4. 00	5. 00		
DIRECT PATIENT CARE SERVICE COST CENTERS							
25. 00 INPATIENT CARE-CONTRACTED						25. 00	
26. 00 PHYSI CI AN SERVI CES	27, 032	0	27, 032	0	27, 032	26. 00	
27. 00 NURSE PRACTITIONER	0	0	0	0	0	27. 00	
28. 00 REGI STERED NURSE	255, 710	0	255, 710	0	255, 710	28. 00	
29. 00 LPN/LVN	0	0	0	0	0	29. 00	
30. 00 PHYSI CAL THERAPY	0	0	0	0	0	30.00	
31. 00 OCCUPATI ONAL THERAPY	25	0	25	0	25	31.00	
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00	
33.00 MEDICAL SOCIAL SERVICES	35, 010	0	35, 010	0	35, 010	33. 00	
34. 00 SPIRITUAL COUNSELING	0	0	0	0	0	34.00	
35. 00 DI ETARY COUNSELING	0	0	0	0	0	35.00	
36. 00 COUNSELING - OTHER	0	0	0	0	0	36.00	
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	24, 298	0	24, 298	0	24, 298	37.00	
38. OO DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00	
39. 00 PATIENT TRANSPORTATION	0	0	0	0	0	39.00	
40.00 I MAGING SERVICES	0	0	0	0	0	40.00	
41. 00 LABS & DIAGNOSTICS	0	0	0	0	0	41.00	
42. 00 MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00	
42.50 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42. 50	
43. 00 OUTPATIENT SERVICES	0	0	0	0	0	43.00	
44.00 PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00	
45.00 PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00	
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00	
100. 00 TOTAL *	342, 075	0	342, 075	0	342, 075	100.00	
* Transfer the amount in column 7 to West 0.5 column 1 Line 51							

 $<sup>^{\</sup>star}$  Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		AD ILICTAENTO	TOTAL ( L E	
		ADJUSTMENTS	TOTAL (col. 5	
		6. 00	± col. 6)	
DLDE	ECT PATIENT CARE SERVICE COST CENTERS	6.00	7. 00	
				25. 00
	ATIENT CARE-CONTRACTED	0	27 022	
	SI CI AN SERVI CES	0	27, 032	26. 00
	SE PRACTITIONER	0	0	27. 00
	I STERED NURSE	0	255, 710	28. 00
29. 00 LPN/		0	0	29. 00
	SI CAL THERAPY	0	0	30.00
	UPATI ONAL THERAPY	0	25	31.00
	ECH/LANGUAGE PATHOLOGY	0	0	32. 00
33. 00 MEDI	ICAL SOCIAL SERVICES	0	35, 010	33. 00
34. 00 SPIR	RI TUAL COUNSELI NG	0	0	34. 00
35. 00 DI ET	TARY COUNSELING	0	0	35. 00
36. 00 COUN	NSELING - OTHER	0	0	36.00
37. 00 HOSP	PICE AIDE & HOMEMAKER SERVICES	0	24, 298	37.00
38. 00 DURA	ABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00 PATI	I ENT TRANSPORTATION	0	o	39. 00
40.00 I MAG	GING SERVICES	0	l ol	40.00
41. 00 LABS	S & DIAGNOSTICS	0	l ol	41.00
42. 00 MEDI	I CAL SUPPLIES-NON-ROUTINE	0	l ol	42. 00
42. 50 DRUG	GS CHARGED TO PATIENTS	0	l ol	42. 50
	PATIENT SERVICES	0	l	43.00
44. 00 PALL	LIATIVE RADIATION THERAPY	0	o	44. 00
	LIATIVE CHEMOTHERAPY	0	l	45.00
	ER PATIENT CARE SERVICES (SPECIFY)	0	l ol	46.00
100. 00 TOTA		0	342, 075	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 15-0030 Hospi ce CCN: 15-1564 Peri od: Worksheet 0-3 From 01/01/2019 12/31/2019 To Date/Time Prepared:

5/18/2020 9:36 am Hospi ce I SUBTOTAL (col. SALARI ES OTHER RECLASSI FI -SUBTOTAL CATI ONS 1 + col . 2) 1.00 2.00 5. 00 3 00 4 00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 3, 929 3, 929 3, 929 25.00 0 PHYSICIAN SERVICES 26.00 164 164 164 26.00 NURSE PRACTITIONER 27.00 27.00 Ω C 0 0 28.00 REGISTERED NURSE 1,547 0 1,547 1,547 28.00 0 29.00 LPN/LVN 29.00 0 30.00 PHYSI CAL THERAPY 0 0 0 0 30.00 OCCUPATIONAL THERAPY 0 0 31.00 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 32.00 33.00 MEDICAL SOCIAL SERVICES 0 212 212 33.00 SPIRITUAL COUNSELING 34.00 0 0 34.00 0 0 35.00 DIETARY COUNSELING 0 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 147 37.00 0 147 37.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 38.00 38.00 0 0 39.00 PATIENT TRANSPORTATION 0 0 0 0 0 0 0 0 0 39.00 40.00 I MAGING SERVICES 40.00 LABS & DIAGNOSTICS 0 41.00 0 0 41.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 42.50 OUTPATIENT SERVICES 0 0 43.00 0 43.00 PALLIATIVE RADIATION THERAPY 0 44.00 C 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY C 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 46.00 100.00 TOTAL \* 3, 929 5, 999 5, 999 100. 00 2.070

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

Transfer the amount in condimination materials and another materials another materials and another materials a						
		ADJUSTMENTS	TOTAL (col. 5			
			± col. 6)			
	T	6. 00	7. 00			
	DI RECT PATIENT CARE SERVI CE COST CENTERS					
25. 00	I NPATIENT CARE-CONTRACTED	0	3, 929			
26.00	PHYSI CI AN SERVI CES	0	164	26. 00		
27.00	NURSE PRACTITIONER	0	0	27. 00		
28. 00	REGI STERED NURSE	0	1, 547	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	212	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	o	36.00		
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	147	37. 00		
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	o	38.00		
39.00	PATI ENT TRANSPORTATION	0	o	39.00		
40.00	I MAGI NG SERVI CES	0	o	40.00		
41.00	LABS & DIAGNOSTICS	0	o	41.00		
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	o	42.00		
42.50	DRUGS CHARGED TO PATIENTS	0	o	42. 50		
43.00	OUTPATIENT SERVICES	0	o	43.00		
44.00	PALLIATIVE RADIATION THERAPY	0	o	44.00		
45.00	PALLI ATI VE CHEMOTHERAPY	0	o	45. 00		
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	o	46.00		
	TOTAL *	0	5, 999	100.00		

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provi der CCN: 15-0030 Hospi ce CCN: 15-1564 Peri od: Worksheet 0-4 From 01/01/2019 To 12/31/2019 Date/Ti me Prepared:

5/18/2020 9:36 am Hospi ce I SUBTOTAL (col. SALARI ES OTHER RECLASSI FI -SUBTOTAL CATI ONS 1 + col . 1.00 2.00 5.00 3 00 4 00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 2, 514 2, 514 2, 514 25.00 0 PHYSICIAN SERVICES 26.00 105 105 105 26.00 NURSE PRACTITIONER 27.00 0 27.00 Ω 0 0 28.00 REGISTERED NURSE 990 0 990 990 28.00 29.00 LPN/LVN 0 29.00 0 30.00 PHYSI CAL THERAPY 0 0 0 30.00 OCCUPATIONAL THERAPY 0 0 31.00 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 32.00 33.00 MEDICAL SOCIAL SERVICES 136 136 136 33.00 0 SPIRITUAL COUNSELING 34.00 0 34.00 0 0 35.00 DIETARY COUNSELING 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 94 37.00 37.00 0 94 0 0 0 0 0 0 0 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 38.00 38.00 0 39. 00 PATIENT TRANSPORTATION 0 0 39.00 40.00 I MAGING SERVICES 40.00 LABS & DIAGNOSTICS 0 0 41.00 0 41.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 42.50 OUTPATIENT SERVICES 0 0 43.00 0 43.00 PALLIATIVE RADIATION THERAPY 0 44.00 C 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY C 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 46.00 100.00 TOTAL \* 2, 514 3, 839 3, 839 100. 00 325

<sup>\*</sup> 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	INPATIENT CARE-CONTRACTED	0	2, 514		25. 00	
26.00	PHYSI CI AN SERVI CES	0	105		26. 00	
27.00	NURSE PRACTITIONER	0	0		27. 00	
28. 00	REGI STERED NURSE	0	990		28. 00	
29. 00	LPN/LVN	0	0		29. 00	
30.00	PHYSI CAL THERAPY	0	0		30.00	
31.00	OCCUPATIONAL THERAPY	0	0		31.00	
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00	
33.00	MEDICAL SOCIAL SERVICES	0	136		33. 00	
34.00	SPIRITUAL COUNSELING	0	o		34.00	
35.00	DI ETARY COUNSELING	0	o		35. 00	
36.00	COUNSELING - OTHER	0	o		36.00	
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	94		37. 00	
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	o		38. 00	
39.00	PATIENT TRANSPORTATION	0	o		39.00	
40.00	I MAGING SERVICES	0	o		40.00	
41.00	LABS & DIAGNOSTICS	0	o		41.00	
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	o		42.00	
42. 50	DRUGS CHARGED TO PATIENTS	0	o		42. 50	
43.00	OUTPATIENT SERVICES	0	o		43.00	
44.00	PALLIATIVE RADIATION THERAPY	0	o		44.00	
45.00	PALLI ATI VE CHEMOTHERAPY	0	o		45. 00	
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	o		46.00	
100.00	TOTAL *	0	3, 839		100.00	

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Heal th	Financial Systems HENRY COUNTY MEMO	DRIAL HOSPITAL		In lie	eu of Form CMS-:	2552-10
	NLLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der C	CN: 15-0030	Peri od:	Worksheet 0-5	
	SES FOR ALLOCATION			From 01/01/2019		
		Hospi ce CCI	N: 15-1564	To 12/31/2019	Date/Time Pre	
				Hospi ce I	5/18/2020 9:3	<u>6 am</u>
	Descriptions		HOSPICE DIREC		TOTAL EXPENSES	
	beschiptions		EXPENSES (se		(sum of cols.	
			instructions		1 + 2)	
				WKST B PART I	,	
				(see		
				instructions)		
			1.00	2. 00	3. 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	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		05/ 46	0 152, 897	152, 897	3.00
4.00	ADMINISTRATIVE & GENERAL		356, 42	· ·	540, 031	4. 00
5.00	PLANT OPERATION & MAINTENANCE		53, 98	62, 522	116, 511	5. 00
6.00	LAUNDRY & LINEN SERVICE HOUSEKEEPING			0	0	6.00
7. 00 8. 00	DIETARY			0	0	7. 00 8. 00
9. 00	NURSING ADMINISTRATION			0 0	0	9.00
10. 00	ROUTINE MEDICAL SUPPLIES		22	9	2, 298	
11. 00	MEDICAL RECORDS			0 3, 056	3, 056	
12. 00	STAFF TRANSPORTATION			0 3,030	0,030	12.00
13. 00	VOLUNTEER SERVICE COORDINATION			0	ő	13. 00
14. 00	PHARMACY		4, 24	4 0	4, 244	1
15. 00	PHYSI CI AN ADMINI STRATI VE SERVI CES		,	0	0	15. 00
16.00	OTHER GENERAL SERVI CE			0 0	0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	17. 00
	LEVEL OF CARE					
50.00	HOSPI CE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		342, 07		342, 075	
52.00	HOSPICE INPATIENT RESPITE CARE		5, 99		5, 999	
53. 00	HOSPI CE GENERAL I NPATI ENT CARE		3, 83	9	3, 839	53. 00
	NONREI MBURSABLE COST CENTERS		Т			
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	61.00
62.00	FUNDRALSING			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM			0	0	63.00
64. 00 65. 00	OTHER PHYSICIAN SERVICES				0	64. 00 65. 00
66. 00	RESI DENTI AL CARE			0	0	66.00
67. 00	ADVERTI SI NG			0	0	67.00
	TELEHEALTH/TELEMONI TORUNG			0	n	

68. 00

69. 00 70. 00 71.00

-14, 555 99. 00

1, 156, 395 100. 00

752, 242

404, 153

68. 00 | TELEHEALTH/TELEMONI TORI NG

100. 00 TOTAL

69.00 THELEHEALTH TELEMONTTORING
69.00 THRIFT STORE
70.00 NURSING FACILITY ROOM & BOARD
71.00 OTHER NONREIMBURSABLE (SPECIFY)
99.00 NEGATIVE COST CENTER

Hear th	Financiai Systems H	ENRY COUNTY MEMO	RIAL HUSPITAL		In Lie	U OF FORM CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provi der Co		Peri od: From 01/01/2019	Worksheet 0-6   Part	
			Hospi ce CCI		To 12/31/2019	Date/Time Pre 5/18/2020 9:3	pared: 6 am
					Hospi ce I		
	Descriptions	TOTAL EXPENSES	CAP REL BLDG &	CAP REL MVBLE	E EMPLOYEE	SUBTOTAL	
	'		FLX	EQUI P	BENEFITS		
					DEPARTMENT		
		0	1. 00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0		2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	152, 897	0		0 152, 897		3.00
4. 00	ADMINISTRATIVE & GENERAL	540, 031	0		0 0	540, 031	4. 00
5. 00	PLANT OPERATION & MAINTENANCE	116, 511	0		0 0	116, 511	
6. 00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	1
7. 00	HOUSEKEEPI NG		0		0 0	0	1
8. 00	DI ETARY		0		0 0	0	8. 00
9. 00	NURSING ADMINISTRATION		0		0 0	0	1
10. 00	ROUTINE MEDICAL SUPPLIES	2, 298	0	1	0 0	2, 298	
11. 00	MEDICAL RECORDS	3, 056	0		0 0	3, 056	
		3,030	0		0 0	3, 030	1
12.00	STAFF TRANSPORTATION	0	0		-	ŭ	12.00
13.00	VOLUNTEER SERVICE COORDINATION	4 244	0		0 0	0	13.00
14.00	PHARMACY	4, 244	0	i .	0 0	4, 244	1
15. 00	PHYSI CI AN ADMINISTRATI VE SERVI CES	0	0		0 0	0	15. 00
16. 00	OTHER GENERAL SERVICE	0	0		0	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0		0	0	17. 00
	LEVEL OF CARE			T			-
50. 00	HOSPICE CONTINUOUS HOME CARE	0			0	0	
51. 00	HOSPICE ROUTINE HOME CARE	342, 075			151, 395	493, 470	
52. 00	HOSPICE INPATIENT RESPITE CARE	5, 999	0		0 916	6, 915	1
53.00	HOSPICE GENERAL INPATIENT CARE	3, 839	0		0 586	4, 425	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0	0	
61. 00	VOLUNTEER PROGRAM	0	0		0	0	61.00
62. 00	FUNDRAI SI NG	0	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 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	68. 00
69.00	THRI FT STORE		0		0 0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD	O				0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	O	0		0 0	0	71. 00
99. 00	NEGATIVE COST CENTER	-14, 555	0	1	0 0		99.00
100.00	TOTAL	1, 156, 395	0		0 152, 897	1, 156, 395	100.00
	i ·	1, 122, 0,0	ŭ	1		.,, 0,0	

COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der C	CN: 15-0030	Peri od:	Worksheet (	0-6
			Hospi ce CC	N: 15-1564	From 01/01/2019 To 12/31/2019	Part I Date/Time I	Prenared:
			nospi ce co	10. 13-1304	10 12/31/2019	5/18/2020	9:36 am
					Hospi ce I		
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	& GENERAL	OPERATION &	LINEN SERVIC	E		
			MAI NTENANCE				
		4. 00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL	540, 031					4. 00
5.00	PLANT OPERATION & MAINTENANCE	99, 727	216, 238	3			5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0		0		6. 00
7.00	HOUSEKEEPI NG	0	0		0		7. 00
8.00	DI ETARY	0	0	)	0		0 8.00
9.00	NURSING ADMINISTRATION	0	0	)	0		9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	1, 967	0	)	0		10.00
11. 00	MEDI CAL RECORDS	2, 616	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	3, 633	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		0		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50. 00
51.00	HOSPICE ROUTINE HOME CARE	422, 381					51. 00
52.00	HOSPICE INPATIENT RESPITE CARE	5, 919	131, 852	2	0 0		0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3, 788	84, 386		0 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		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		o		69. 00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		o o		0 71.00
99. 00	NEGATIVE COST CENTER	0	O		o o		0 99.00
100.00	TOTAL	540, 031	216, 238	3	0 0		0 100. 00
		•					•

Heal th Financial	Systems		HENRY COUNTY MEMORI	AL F	10SPI	TAL		In Lieu d	of Fo	rm CMS-2	2552-10
COOT ALLOCATION	HOODITAL BACED	HOODLOE OFNERAL	OFFILL OF COOTS	_		0.011 45 0.000	T				

Heal th	Financial Systems	HENRY COUNTY MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der Co	CN: 15-0030	Peri od:	Worksheet 0-6	
					From 01/01/2019	Part I	
			Hospi ce CCI	N: 15-1564	To 12/31/2019	Date/Time Pre	
					Heeni ee I	5/18/2020 9:3	<u> 6 am</u>
	Decemintians	NUDCLNC	DOUTLNE	MEDICAL	Hospi ce I	VOLUNTEED	
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATI ON	SERVI CE	
		9. 00	SUPPLIES 10.00	11. 00	12.00	COORDI NATI ON 13. 00	
	GENERAL SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MUBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						ł
	1						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	NURSING ADMINISTRATION	0					9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	4, 265				10.00
11. 00	MEDI CAL RECORDS	이		5, 6	72		11. 00
12. 00	STAFF TRANSPORTATION	이			0		12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	0			0	0	
14. 00	PHARMACY	0			0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15. 00
16. 00	OTHER GENERAL SERVICE	0			0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	0	50. 00
51.00	HOSPICE ROUTINE HOME CARE	0	4, 223	5, 6	16 0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	26		34 0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	16		22 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	o			0	0	64. 00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65. 00
66.00	RESI DENTI AL CARE	o			0	0	66. 00
67.00	ADVERTI SI NG	o			0	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
69.00	THRI FT STORE	o			0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	l			0	0	•
99. 00	NEGATIVE COST CENTER	o	0		0 0	0	•
100.00	TOTAL	ol	4, 265	5, 6	72 0	0	100.00
	1	- 1				•	

near th	Financiai Systems He	ENRY COUNTY MEN	URIAL HUSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	ILLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS			Period: From 01/01/2019		
			Hospi ce CC	N: 15-1564	To 12/31/2019	Date/Time Pre 5/18/2020 9:3	
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	_ PATI ENT/	TOTAL	
	·		ADMI NI STRATI VE	SERVI CE	RESI DENTI AL		
			SERVI CES		CARE SERVICES		
		14. 00	15. 00	16.00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP					I	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					I	3.00
4. 00	ADMINISTRATIVE & GENERAL					I	4. 00
5. 00	PLANT OPERATION & MAINTENANCE					I	5. 00
6. 00	LAUNDRY & LINEN SERVICE					I	6.00
7. 00	HOUSEKEEPI NG					I	7. 00
8.00	DI ETARY					I	8.00
9. 00	NURSING ADMINISTRATION					I	9.00
10. 00	ROUTINE MEDICAL SUPPLIES					I	10.00
11. 00	MEDICAL RECORDS					I	11.00
	1					I	
12.00	STAFF TRANSPORTATION					I	12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	7, 877				I	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	1		I	15. 00
16. 00	OTHER GENERAL SERVICE	0			0	I	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE	T					
50. 00	HOSPICE CONTINUOUS HOME CARE	0	0	•	0	0	
51. 00	HOSPICE ROUTINE HOME CARE	7, 799		•	0	933, 489	1
52.00	HOSPICE INPATIENT RESPITE CARE	48			0	144, 794	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	30	0	)	0 0	92, 667	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			o	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
69. 00	THRI FT STORE	0			0	0	1
70. 00	NURSING FACILITY ROOM & BOARD					0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	n	l o		o	Ö	1
99. 00	NEGATIVE COST CENTER	0	Ö	•	o o	-14, 555	1
	TOTAL	7, 877			o o		
. 55. 50	1 : = :::=	1,377		1	-1	., 100, 070	1.00.00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GI STATISTICAL BASIS	ENERAL SERVICE COSTS Provider CC Hospice CCN	Period: From 01/01/2019 To 12/31/2019	Worksheet 0-6 Part II Date/Time Prepared:

			Hospi ce cci	: 15-1564   1	0 12/31/2019	5/18/2020 9:3	
					Hospi ce I	07 107 2020 710	<u> </u>
	Cost Center Descriptions	CAP REL BLDG & CA	P REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	F	FLX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (D	OLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
		(	/	(GROSS		COSTS)	
				SALARI ES)			
		1.00	2.00	3.00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	0	0	129, 721			3. 00
4.00	ADMINISTRATIVE & GENERAL		0	.27,721	-540, 031	630, 919	4. 00
5. 00	PLANT OPERATION & MAINTENANCE		o o	0	0 10, 001	116, 511	5. 00
6. 00	LAUNDRY & LINEN SERVICE		0	0	0	0	ı
7. 00	HOUSEKEEPI NG	0	0	0	0	0	7. 00
8.00	DI ETARY	0	0	0	0	0	1
		0	0	0	U		1
9.00	NURSING ADMINISTRATION	0	٠	0	U	0	
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	2, 298	1
11. 00	MEDI CAL RECORDS	0	0	0	0	3, 056	1
12. 00	STAFF TRANSPORTATION	0	0	0	0	0	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13. 00
14. 00	PHARMACY	0	0	0	0	4, 244	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15. 00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50. 00
51.00	HOSPICE ROUTINE HOME CARE			128, 447	0	493, 470	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	o	o	777	0	6, 915	1
53. 00	HOSPICE GENERAL INPATIENT CARE	o	o	497	0	4, 425	
	NONREI MBURSABLE COST CENTERS	-1				., .=-	
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61. 00	VOLUNTEER PROGRAM	0	0	0	0	0	61. 00
62. 00	FUNDRAI SI NG		0	0	0	0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0	0	0	0	63. 00
64. 00	PALLI ATI VE CARE PROGRAM		0	0	0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65. 00
		0	0	0	0	0	1
66. 00	RESI DENTI AL CARE	0	0	0	U	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	68. 00
69. 00	THRI FT STORE	0	O	0	0	0	69. 00
	NURSING FACILITY ROOM & BOARD				0		70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	
	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	152, 897		540, 031	
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	1. 178660		0. 855943	101. 00

Health Financial Systems H	ENRY COUNTY MEN		In Lieu of Form CMS			
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provi der Co		Peri od:	Worksheet 0-6	
STATISTICAL BASIS				From 01/01/2019		
		Hospi ce CCI	N: 15-1564	To 12/31/2019		
					5/18/2020 9: 3	<u>6 am </u>
				Hospi ce I		
Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMI NI STRATI ON	
	MAI NTENANCE	(IN-FACILITY		DAYS)		
	(SQUARE FEET)	DAYS)			(DI RECT NURS.	
					HRS. )	
	5 00	6 00	7 00	9 00	0.00	

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)		DAYS)	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	T				T	
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE	247, 821					5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	)			6. 00
7. 00	HOUSEKEEPING	0		0			7. 00
8.00	DI ETARY	0		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	0		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	1					
50. 00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51. 00	HOSPICE ROUTINE HOME CARE					0	51. 00
52. 00	HOSPICE INPATIENT RESPITE CARE	151, 110	0		0	0	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	96, 711	0	0	0	0	53. 00
	NONREI MBURSABLE COST CENTERS	T				1	
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 PHYSI CI AN SERVI CES	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	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	0	71. 00
99. 00	NEGATI VE COST CENTER		_	_	_	_	99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	216, 238		0	0 000000		100.00
101.00	UNIT COST MULTIPLIER	0. 872557	0. 000000	0.000000	0. 000000	0. 000000	101.00

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL		In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVI CE COSTS	Provi der CCN:	15-0030	Peri od: From 01/01/2019	Worksheet 0-6
STATISTICAL BASIS		Hospice CCN:	15-1564		Date/Time Prepared:

SIAIIS	TITCAL BASIS		Hospi ce CCI	N: 15-1564	To 12/31/2019	Date/Time Pre 5/18/2020 9:3	
	Cost Center Descriptions		MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATIO	Hospi ce I VOLUNTEER SERVI CE COORDI NATI ON	PHARMACY (CHARGES)	O am
		(PATIENT DAYS)		(MI LEAGE)	(HOURS OF SERVICE)		
	ASSUEDAL ASSUEDA	10. 00	11. 00	12.00	13. 00	14. 00	
1 00	GENERAL SERVICE COST CENTERS	1		I	1		1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 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	1					6. 00
7. 00	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION						9. 00
10.00	ROUTINE MEDICAL SUPPLIES	4, 174					10.00
11. 00	MEDI CAL RECORDS		4, 174				11. 00
12.00	STAFF TRANSPORTATION				0		12. 00
13.00	VOLUNTEER SERVICE COORDINATION				0 0		13. 00
14. 00	PHARMACY				0 0	9, 112	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES				0	0	
16. 00	OTHER GENERAL SERVICE				0	0	1
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
EO 00	LEVEL OF CARE		0	ı	0 0	0	FO 00
50. 00 51. 00	HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE	4, 133	4, 133	1	0 0	0 9, 022	
51.00	HOSPICE ROUTINE HOME CARE  HOSPICE INPATIENT RESPITE CARE	4, 133	4, 133		0 0	9, 022 55	1
53. 00	HOSPICE GENERAL INPATIENT CARE	16	16		0 0	35	
33.00	NONREI MBURSABLE COST CENTERS	10	10	1	0	33	33.00
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	66. 00
67. 00	ADVERTI SI NG				0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG				0	0	
69. 00					0 0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70.00
	OTHER NONREIMBURSABLE (SPECIFY)	1				0	7 00
	NEGATIVE COST CENTER	4 345	E 470			7 077	99. 00 100. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I) UNIT COST MULTIPLIER	4, 265 1. 021802	5, 672 1. 358888		0. 000000	0. 864464	
101.00	ONI I GOOT WIDE ITTELEN	1. 02 1002	1. 330000	0.0000	0.000000	0.004404	1101.00

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STATISTICAL BASIS	SERVI CE COSTS	Provider CCN: Hospice CCN:		Peri od: From 01/01/2019 To 12/31/2019	Worksheet 0-6 Part II Date/Time Prepared: 5/18/2020 9:36 am		

						5/18/2020 9: 3	36 am
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
	'	ADMI NI STRATI VE	SERVI CE	RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICES			
		(PATIENT DAYS)	BASIS)	(IN-FACILITY			
		,	ĺ	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	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	NURSING ADMINISTRATION						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	ł				15. 00
16. 00	OTHER GENERAL SERVICE		0	1			16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50. 00	HOSPICE CONTINUOUS HOME CARE	0	•	)			50. 00
51. 00	HOSPICE ROUTINE HOME CARE	0		)			51. 00
52. 00	HOSPICE INPATIENT RESPITE CARE	0		)  C	)		52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	) C			53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0	)			60.00
61. 00	VOLUNTEER PROGRAM		0	)			61. 00
62.00	FUNDRAI SI NG		0				62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0	)			63. 00
64.00	PALLIATIVE CARE PROGRAM		0				64. 00
65.00	OTHER PHYSICIAN SERVICES		0				65. 00
66.00	RESI DENTI AL CARE	0	0	) c	)		66. 00
67.00	ADVERTI SI NG						67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		l 0				68. 00
69. 00	THRI FT STORE	1					69. 00
70. 00	NURSING FACILITY ROOM & BOARD	1					70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	ol c			71. 00
99. 00	NEGATIVE COST CENTER		Ĭ				99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0				100.00
	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 000000			101.00
101.00	S 333. MOETT LIEN	0.00000	0.00000		T.		1.01.00

	Financial Systems H TONMENT OF HOSPITAL-BASED HOSPICE SHARED SERV	ENRY COUNTY MEMO	ORIAL HOSPITAL Provider Co		In Lie	u of Form CMS-:	
	TUNMENT OF HUSPITAL-BASED HUSPICE SHARED SERV	LICE COSIS BY	Provider Co	JN: 15-0030	From 01/01/2019	Worksheet 0-7	
LLVLL	OF CARE		Hospi ce CCI	N: 15-1564	To 12/31/2019	Date/Time Pre 5/18/2020 9:3	
					Hospi ce I		
				Charges by	/ LOC (from Provi	der Records)	
	Cook Cooker Dooreinting	F Wi+ C	0+ +- 0	НСНС	LIDLIC	HI RC	
	Cost Center Descriptions	From Wkst. C, (Part I, Col. 9		НСНС	HRHC	HI KC	
		0	1. 00	2.00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS	U	1.00	2.00	3.00	4.00	
1. 00	PHYSI CAL THERAPY	66, 00	0. 720466		0 0	0	1.00
2.00	OCCUPATI ONAL THERAPY	67. 00	0. 613829		o o	0	
3.00	SPEECH PATHOLOGY	68. 00	0. 531077		0 0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73. 00	0. 412957		0 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96. 00					5.00
6.00	LABORATORY	60.00	0. 182841		0 0	0	6.00
6. 01	BLOOD LABORATORY	60. 01	0. 000000		0 0	0	6. 01
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0. 142889		0 0	0	7.00
8. 00	OTHER OUTPATIENT SERVICE COST CENTER	93. 00					8.00
9. 00	RADI OLOGY-THERAPEUTI C	55. 00					9. 00
10. 00	CARDI AC REHAB	76. 00	0. 362841		0 0	0	10.00
11. 00	Totals (sum of lines 1-11)						11. 00
		Charges by LOC (from Provider Records)		Shared Servi	ice Costs by LOC		
	Cost Center Descriptions		HCHC (col. 1 x	HRHC (col. 1	xHIRC (col. 1 x	HGLP (col. 1 x	
			col . 2)	col . 3)	col . 4)	col . 5)	
		5.00	6.00	7. 00	8. 00	9. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	0	0		0 0	0	
2.00	OCCUPATI ONAL THERAPY	0	0		0 0	0	
3.00	SPEECH PATHOLOGY	0	0		0 0	0	
4. 00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED						5. 00
6.00	LABORATORY RLOOD LABORATORY	0	0		0 0	0	
6 N1	IRLUUU LARURATURV	ı Ol	Ω	1	OI OI	0	1 6 O

0

0

6. 01

7.00

8. 00

9. 00

0 10.00

0 11.00

6. 01

7.00

8.00

9.00

BLOOD LABORATORY

10.00 CARDI AC REHAB

RADI OLOGY-THERAPEUTI C

11.00 Totals (sum of lines 1-11)

MEDICAL SUPPLIES CHARGED TO PATIENTS OTHER OUTPATIENT SERVICE COST CENTER

Health Financial Systems	HENRY COUNTY MEMOR	IAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM	COST	Provider CCN: 15-0030	Peri od: From 01/01/2019	Worksheet 0-8

Hospi ce CCN: 15-1564 To 12/31/2019 Date/Time Prepared: 5/18/2020 9:36 am Hospi ce I TITLE XVIII TITLE XIX TOTAL MEDI CARE MEDI CAI D 3. 00 1 00 2 00 HOSPICE CONTINUOUS HOME CARE 1.00 Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, 0 1.00 line 11) Total unduplicated days (Wkst. S-9, col. 4, line 10)
Total average cost per diem (line 1 divided by line 2) 2.00 2.00 0 0.00 3.00 3.00 4.00 Unduplicated program days (Wkst. S-9 col. as appropriate, line 10) 4.00 Program cost (line 3 times line 4) 5.00 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, 933, 489 6.00 line 11) 7.00 Total unduplicated days (Wkst. S-9, col. 4, line 11) 4, 133 7.00 8.00 Total average cost per diem (line 6 divided by line 7) 225.86 8.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 9.00 3, 167 36 9.00 10.00 Program cost (line 8 times line 9) 715, 299 8, 131 10.00 HOSPICE INPATIENT RESPITE CARE Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, 144, 794 11 00 11 00 line 11) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 25 12.00 13.00 Total average cost per diem (line 11 divided by line 12) 5, 791. 76 13.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 14.00 21 0 14.00 Program cost (line 13 times line 14) 121, 627 15.00 0 15.00 HOSPICE GENERAL INPATIENT CARE 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, 92, 667 16.00 line 11) Total unduplicated days (Wkst. S-9, col. 4, line 13) 17 00 17 00 16 Total average cost per diem (line 16 divided by line 17) 5, 791. 69 18.00 18.00 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 14 Program cost (line 18 times line 19)
TOTAL HOSPICE CARE 20.00 81,084 11,583 20.00

1, 170, 950

4, 174

280. 53 23. 00

21.00

22.00

21.00

22.00

Total cost (sum of line 1 + line 6 + line 11 + line 16)

Total unduplicated days (Wkst. S-9, col. 4, line 14)

23.00 Average cost per diem (line 21 divided by line 22)

	Financial Systems HENRY COUNTY MEMOR			u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0030	Peri od: From 01/01/2019	Worksheet L Parts I-III	
			To 12/31/2019	Date/Time Pre	
		T: 11 NO.11 1		5/18/2020 9: 3	6 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			11.00	
	CAPITAL FEDERAL AMOUNT				1
. 00	Capital DRG other than outlier			577, 992	1.0
01	Model 4 BPCI Capital DRG other than outlier	0	1.0		
. 00	Capital DRG outlier payments			8, 295	2.0
. 01	Model 4 BPCI Capital DRG outlier payments			0	2.0
00	Total inpatient days divided by number of days in the cost re	porting period (see inst	ructions)	21. 05	3.0
00	Number of interns & residents (see instructions)			0. 00	
. 00	Indirect medical education percentage (see instructions)			0. 00	
. 00	Indirect medical education adjustment (multiply line 5 by the 1.01)(see instructions)	0	6.0		
00	Percentage of SSI recipient patient days to Medicare Part A p 30) (see instructions)	0. 00	7.0		
. 00	Percentage of Medicaid patient days to total days (see instru	0.00	8.0		
. 00	Sum of lines 7 and 8	0.00	9.0		
0. 00	Allowable disproportionate share percentage (see instructions	0.00			
1. 00	Disproportionate share adjustment (see instructions)			0	11.0
2. 00	Total prospective capital payments (see instructions)			586, 287	12.0
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
. 00	Program inpatient routine capital cost (see instructions)			0	1. C
. 00	Program inpatient ancillary capital cost (see instructions)			0	2.0
00	Total inpatient program capital cost (line 1 plus line 2)			0	3.0
. 00	Capital cost payment factor (see instructions)			0	4.0
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.0
				4 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00	
. 00	Program inpatient capital costs (see instructions)			0	1.0
. 00	Program inpatient capital costs for extraordinary circumstance	es (see instructions)		0	2.0
. 00	Net program inpatient capital costs (line 1 minus line 2)	,		0	3.0
00	Applicable exception percentage (see instructions)			0.00	4.0
. 00	Capital cost for comparison to payments (line 3 x line 4)			0	5.0
. 00	Percentage adjustment for extraordinary circumstances (see in	structions)		0.00	6.0
. 00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 x	: line 6)	0	7. C
. 00	Capital minimum payment level (line 5 plus line 7)			0	8.0
. 00	Current year capital payments (from Part I, line 12, as appli			0	9.0
10.00	Current year comparison of capital minimum payment level to c			0	10.0
1 00	Carryover of accumulated capital minimum payment lovel over c	anital nayment (from pri	05 11005	0	111 /

0 11.00

0 12.00

0 13.00

0 14.00

0 15.00

0 16.00 0

17.00

11.00 | Carryover of accumulated capital minimum payment level over capital payment (from prior year

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Carryover of accumulated capital minimum payment level over capital payment for the following period

Worksheet L, Part III, line 14)

(if line 12 is negative, enter the amount on this line)

17.00 Current year exception offset amount (see instructions)

15.00 Current year allowable operating and capital payment (see instructions)

16.00 Current year operating and capital costs (see instructions)

12.00

13.00

14.00

Heal th	Financial Systems	HENRY COUNTY MEM	IORIAL HOSPITAL		In Lieu of Form CMS-2552-10			
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider Co		Peri od:	Worksheet M-1		
			Component (	From 01/01/2019   Component CCN: 15-8520			nared.	
		Component	3014. 13 0320	10 12/31/2017	Date/Time Prep 5/18/2020 9:30			
					RHC I	Cost		
		Compensati on	Other Costs	Total (col. 1	Recl assi fi cati	Recl assi fi ed		
				+ col . 2)	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, 287, 154	22, 077	1, 309, 23	1 0	1, 309, 231	1.00	
2.00	Physi ci an Assi stant	0	0		0	0	2.00	
3.00	Nurse Practitioner	655, 376	0	655, 37	6 15, 146	670, 522	3.00	
4.00	Visiting Nurse	0	0		0	0	4. 00	
5.00	Other Nurse	377, 413	0	377, 41	3 0	377, 413	5. 00	
/ 00	Clinian Barrahalanian		1 ^		م ام	ا م	/ 00	

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-0030	Period: Worksheet M-1 From 01/01/2019			
	Component CCN: 15-8520	To 12/31/2019 Date/Time Prepared: 5/18/2020 9:36 am			

			Component	CCN. 13-032	0   10	12/31/2019	5/18/2020 9: 3	
						RHC I	Cost	
	·	Adjustments	Net Expenses					
			for Allocation	ı				
			(col. 5 + col.					
			6)					
		6.00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	1, 309, 231					1. 00
2.00	Physician Assistant	0	0	1				2. 00
3.00	Nurse Practitioner	0	670, 522	2				3. 00
4.00	Visiting Nurse	0	0	)				4. 00
5.00	Other Nurse	0	377, 413	s				5. 00
6.00	Clinical Psychologist	0	0	)				6. 00
7.00	Clinical Social Worker	0	49, 402	2				7. 00
8.00	Laboratory Techni ci an	0	0	1				8. 00
9.00	Other Facility Health Care Staff Costs	0	435, 119	1				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	2, 841, 687	'				10. 00
11. 00	Physician Services Under Agreement	0	0	)				11. 00
12.00	Physician Supervision Under Agreement	0	0	1				12. 00
13.00	Other Costs Under Agreement	0	0	1				13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0	1				14. 00
15. 00	Medical Supplies	0	177, 992	2				15. 00
16. 00	Transportation (Health Care Staff)	0	0	)				16. 00
17. 00	Depreciation-Medical Equipment	0	0	1				17. 00
18. 00	Professional Liability Insurance	0	43, 293	<b> </b>				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	221, 285					21. 00
22. 00	Total Cost of Health Care Services (sum of	0	3, 062, 972	2				22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES	ما						
23. 00	Pharmacy	0	0	1				23. 00
24. 00	Dental	0	0	1				24. 00
25. 00	Optometry	0	0	1				25. 00
25. 01	Tel eheal th	0	0	1				25. 01
25. 02	Chronic Care Management	0	0	1				25. 02
26. 00	All other nonreimbursable costs	0	0	9				26. 00
27. 00	Nonallowable GME costs	_	_					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	O	0	9				28. 00
	through 27)							-
20.00	FACILITY OVERHEAD	275 450	200 205					20.00
29. 00	Facility Costs	-275, 459						29. 00
30.00	Administrative Costs	-144, 344	· ·	1				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-419, 803	1, 172, 174	1				31.00
22 00	30)	410 000	4 DOE 144					22.00
32. 00	Total facility costs (sum of lines 22, 28 and 31)	-419, 803	4, 235, 146	<u>'</u>				32. 00
	Jana 51)	ı		1				1

Health Financial Systems	HENRY COUNTY MEM	ORIAL HOSPITAL	In Lieu of Form CMS-2552-1			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-0030	Peri od: From 01/01/2019	Worksheet M-1	
		Component	CCN: 15-8525	To 12/31/2019		
				RHC II	Cost	
	Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Recl assi fi ed	
			+ col . 2)	ons	Trial Balance	

						5/ 18/ 2020 9: 30	o alli
						RHC II Cost	
		Compensation	Other Costs	Total (col 1	Recl assi fi cati	Reclassi fied	
		oomponed tron	011101 00010	+ col . 2)	ons	Trial Balance	
				+ (01. 2)	0115		
						(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	2, 493, 255	52, 900	2, 546, 15	-1, 122, 773	1, 423, 382	1.00
2.00	Physi ci an Assi stant	0		1	)		2.00
3. 00	Nurse Practitioner	1, 505, 667	0	1, 505, 66	103, 575	1, 609, 242	3. 00
4. 00		1, 303, 007	0	1, 303, 00	103, 373		
	Visiting Nurse		0	1	J 0	0	4. 00
5.00	Other Nurse	399, 223	0	399, 223	3 0	399, 223	5. 00
6.00	Clinical Psychologist	0	0	(	0	0	6. 00
7.00	Clinical Social Worker	62, 974	51, 747	114, 72	1 0	114, 721	7. 00
8.00	Laboratory Techni ci an	0	0		0	0	8. 00
9. 00	Other Facility Health Care Staff Costs	698, 249	0	698, 24	0	698, 249	9. 00
10.00	Subtotal (sum of lines 1 through 9)		104 (47				10.00
		5, 159, 368	104, 647	5, 264, 01	-1,019,198		
11. 00	Physician Services Under Agreement	0	0	1	ט	0	11. 00
12.00	Physician Supervision Under Agreement	0	0	) (	0	0	12.00
13.00	Other Costs Under Agreement	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	452, 775	452, 77!	5	452, 775	15. 00
16. 00	Transportation (Health Care Staff)	0	432,773	452,77		432,773	16. 00
		0	U				
17. 00	Depreciation-Medical Equipment	0	0	1	ט	0	17. 00
18. 00	Professional Liability Insurance	0	0	(	0	0	18. 00
19.00	Other Health Care Costs	0	0	)	0	0	19. 00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	452, 775	452, 77!	5	452, 775	21. 00
22. 00	Total Cost of Health Care Services (sum of	5, 159, 368		1			22. 00
22.00		3, 139, 300	337, 422	3, 710, 790	-1,019,190	4, 097, 392	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0	1	0		23. 00
24.00	Dental	0	0	(	0	0	24. 00
25.00	Optometry	0	0	)	0	0	25. 00
25. 01	Tel eheal th	0	0		0	ol	25. 01
25. 02	Chronic Care Management	0	0	,	0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	26. 00
		U	U	Ί '		٥	
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	(	0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	1, 337, 589	1, 337, 589	9 0	1, 337, 589	29. 00
30. 00	Administrative Costs	668, 135					30.00
31. 00	Total Facility Overhead (sum of lines 29 and				1		31. 00
31.00		000, 135	2, 000, 481	3, 310, 010	-031, 148	2, 401, 408	31.00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	5, 827, 503	3, 207, 903	9, 035, 40	-1, 850, 346	7, 185, 060	32. 00
	and 31)			[			

Health Financial Systems	HENRY COUNTY MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS	Provi der CCN: 15-0030	Peri od: Worksheet M-1 From 01/01/2019			
	Component CCN: 15-8525	To 12/31/2019 Date/Time Prepared			

Adjustments				Component	CCN. 13-032	3   10 12	./ 31/ 2017	5/18/2020 9:3	
FACILITY HEALTH CARE STAFF COSTS						RHO	CII		
Cool   5 + col   6		·	Adjustments	Net Expenses					
FACILITY HEALTH CARE STAFF COSTS			•	for Allocation	1				
FACILITY HEALTH CARE STAFF COSTS				(col. 5 + col.					
FACILITY HEALTH CARE STAFF COSTS				6)					
1.00			6. 00	7. 00					
2.00									
3.00	1.00		0	1, 423, 382	2				1.00
4.00	2.00	Physician Assistant	0	(	)				2. 00
5.00	3.00	Nurse Practitioner	0	1, 609, 242	2				3. 00
6.00	4.00	Visiting Nurse	0	(	)				4. 00
7.00	5.00	Other Nurse	0	399, 223	3				5. 00
B. 00	6.00	Clinical Psychologist	0	(					6. 00
9.00   Other Facility Health Care Staff Costs   0   698, 249   10.00   Subtotal (sum of lines 1 through 9)   0   4,244,817   10.00   11.00   Physician Services Under Agreement   0   0   0   12.00   13.00   14.00   14.00   15.00   15.00   15.00   15.00   15.00   15.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   17.00   16.00   16.00   16.00   17.00   16.00   17.00   16.00   16.00   17.00   16.00   17.00   16.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.00	7.00	Clinical Social Worker	0	114, 721					7. 00
10. 00   Subtotal (sum of lines 1 through 9)   0   4,244,817   10. 00	8.00	Laboratory Techni ci an	0	(					8. 00
11.00   Physician Services Under Agreement   0   0   0   12.00   Physician Supervision Under Agreement   0   0   0   12.00   13.00   14.00   14.00   14.00   15.00   15.00   16.00	9.00	Other Facility Health Care Staff Costs	0	698, 249	9				9. 00
12. 00	10.00	Subtotal (sum of lines 1 through 9)	0	4, 244, 817	7				10.00
13. 00   Other Costs Under Agreement   0   0   0   0   14. 00   14. 00   14. 00   14. 00   15. 00   14. 00   15. 00   16. 00   17. 00   16. 00   17. 00   16. 00   17. 00   16. 00   17. 00   18. 00   18. 00   19. 00   19. 00   19. 00   18. 00   19. 00	11.00	Physician Services Under Agreement	0	(					11. 00
14.00   Subtotal (sum of lines 11 through 13)	12.00	Physician Supervision Under Agreement	0	(					12.00
15.00   Medical Supplies	13.00	Other Costs Under Agreement	0	(					13.00
16. 00 Transportation (Health Care Staff) 0 0 0 17. 00 Depreciation-Medical Equipment 0 0 0 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 19. 00 1	14.00	Subtotal (sum of lines 11 through 13)	0	(					14. 00
17. 00   Depreciation-Medical Equipment   0   0   0   18. 00   18. 00   Professional Liability Insurance   0   0   0   18. 00   0   19. 00   19.	15.00	Medical Supplies	0	452, 775	5				15. 00
18. 00	16.00	Transportation (Health Care Staff)	0	(					16. 00
19. 00 Other Health Care Costs 0 0 0 0 19. 00 20. 00 Allowable GME Costs 20. 00 21. 00 Subtotal (sum of lines 15 through 20) 0 452,775 21. 00 22. 00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)  COSTS OTHER THAN RHC/FOHC SERVICES  23. 00 Pharmacy 0 0 0 24. 00 Dental 0 0 0 25. 00 Optometry 0 0 0 0 25. 00 Optometry 0 0 0 0 25. 00 Chronic Care Management 0 0 0 0 25. 01 Tel eheal th 0 0 0 0 25. 02 Chronic Care Management 0 0 0 0 26. 00 All other nonreimbursable costs 0 0 0 0 27. 00 Nonallowable GME costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17.00	Depreciation-Medical Equipment	0	(					17. 00
20. 00   Allowable GME Costs   20. 00   21. 00   22. 00   22. 00   22. 00   22. 00   23. 00   22. 00   23. 00   24. 00   23. 00   24. 00   24. 00   25. 00   25. 00   25. 00   26. 00   25. 00   26. 00	18.00	Professional Liability Insurance	0	(					18. 00
21.00   Subtotal (sum of lines 15 through 20)   0   452,775   22.00	19.00	Other Health Care Costs	0	(					19. 00
22.00   Total Cost of Health Care Services (sum of lines 10, 14, and 21)   COSTS OTHER THAN RHC/FOHC SERVICES     23.00	20.00	Allowable GME Costs							20. 00
Li nes 10, 14, and 21)	21.00	Subtotal (sum of lines 15 through 20)	0	452, 775	5				21. 00
COSTS OTHER THAN RHC/FOHC SERVICES   Pharmacy	22.00	Total Cost of Health Care Services (sum of	0	4, 697, 592	2				22. 00
23.00 Pharmacy		lines 10, 14, and 21)							
24.00   Dental   O   O   O   O   O   O   O   O   O		COSTS OTHER THAN RHC/FQHC SERVICES							
25. 00   Optometry   O		Pharmacy	0	(	)				23. 00
25. 01 Tel eheal th	24.00	Dental	0	(	)				
25. 02 Chronic Care Management 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00	Optometry	0	(	)				25. 00
26. 00   All other nonreimbursable costs   0   0   0   26. 00   27. 00   28. 00   Nonallowable GME costs   0   0   0   0   28. 00   28. 00   1   1   1   1   1   1   1   1   1	25. 01	Tel eheal th	0	(	)				25. 01
27.00   Nonallowable GME costs   27.00   28.00     Total Nonreimbursable Costs (sum of lines 23   0   0   0   28.00	25. 02	Chronic Care Management	0	(					25. 02
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00	All other nonreimbursable costs	0	(					26. 00
through 27) FACILITY OVERHEAD  29. 00 Facility Costs 30. 00 Administrative Costs 31. 00 Total Facility Overhead (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28 -788, 066 6, 396, 994)  29. 00 -673, 316 664, 273 -114, 750 1, 035, 129 30. 00 -788, 066 1, 699, 402 31. 00 32. 00 32. 00 32. 00	27.00	Nonallowable GME costs							27. 00
FACILITY OVERHEAD  29. 00 30. 00 31. 00 31. 00 32. 00 Total facility costs (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28  788, 066  788, 066  644, 273  1, 035, 129  1, 035, 129  31. 00  31. 00  32. 00  32. 00  32. 00	28.00	Total Nonreimbursable Costs (sum of lines 23	0	(					28. 00
29.00   Facility Costs   -673,316   664,273   29.00   30.00   Administrative Costs   Total Facility Overhead (sum of lines 29 and 30)   Total facility costs (sum of lines 22, 28   -788,066   6,396,994   32.00   32.00   32.00   32.00   32.00   33.									
30.00 Administrative Costs									
31.00 Total Facility Overhead (sum of lines 29 and 31.00 31.00 Total facility costs (sum of lines 22, 28 -788,066 6, 396, 994 32.00					1				
30) 32.00 Total facility costs (sum of lines 22, 28 -788,066 6,396,994 32.00					1				1
32.00 Total facility costs (sum of lines 22, 28 -788,066 6,396,994 32.00	31. 00		-788, 066	1, 699, 402	2				31.00
		,							
and 31)	32. 00		-788, 066	6, 396, 994	1				32. 00
		and 31)			1				1

Heal th	Financial Systems	HENRY COUNTY MEM	NORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC	SERVI CES	Provi der Co		Period: From 01/01/2019	Worksheet M-2	
			Component	CCN: 15-8520	To 12/31/2019	Date/Time Pre 5/18/2020 9:3	
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)	col. 2 or col. 4	
		1.00	2. 00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	4. 23					1. 00
2.00	Physician Assistant	0. 00		_,			2. 00
3.00	Nurse Practitioner	4. 15					3. 00
4.00	Subtotal (sum of lines 1 through 3)	8. 38			26, 481	26, 673	
5.00	Visiting Nurse	0. 00				0	5. 00
6.00	Clinical Psychologist	0. 00				0	6. 00
7. 00	Clinical Social Worker	0. 48		•		299	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4	8. 86	26, 972			26, 972	8. 00
9. 00	through 7) Physician Services Under Agreements		0			0	9. 00
9.00	Prhysician Services under Agreements					U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE			VI CES			
10.00	Total costs of health care services (from W					3, 062, 972	10.00
11. 00						0	
12. 00	Cost of all services (excluding overhead) (					3, 062, 972	
13. 00	Ratio of hospital-based RHC/FQHC services (					1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (f			ne 31)		1, 172, 174	
15.00	Parent provider overhead allocated to facil	ity (see instruc	ctions)			3, 651, 487	
16.00	Total overhead (sum of lines 14 and 15)					4, 823, 661	
17. 00	,					0	
	Enter the amount from line 16	OUC comulace (Li	no 12 v lino 1	0)		4, 823, 661	
	Overhead applicable to hospital-based RHC/F Total allowable cost of hospital-based RHC/					4, 823, 661 7, 886, 633	
20.00	Tiotal allowable cost of hospital-based RHC/	i uno sei vices (s	sum OF FIRES TO	and 19)		1,000,033	20.00

ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der Co		Peri od: From 01/01/2019	Worksheet M-2	
			Component		To 12/31/2019	Date/Time Prep 5/18/2020 9:30	
					RHC II	Cost	
	<u> </u>	Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	5. 35			· ·		1.00
2.00	Physician Assistant	0. 00		_,			2.00
3.00	Nurse Practitioner	10. 72	23, 276	2, 10	0 22, 512		3.00
4.00	Subtotal (sum of lines 1 through 3)	16. 07			44, 982	44, 982	
5.00	Visiting Nurse	0. 00				0	
6. 00	Clinical Psychologist	0.00				0	6. 00
7.00	Clinical Social Worker	0. 59				1, 394	
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0. 00	0			0	7. 02
	onl y)						
8. 00	Total FTEs and Visits (sum of lines 4	16. 66	44, 979			46, 376	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO LICEDITAL DACE	D DUC/FOUR CED	VI CEC		1. 00	
10 00	Total costs of health care services (from W			VICES		4, 697, 592	10 00
11. 00	Total nonreimbursable costs (from Wkst. M-1						11.00
12. 00	Cost of all services (excluding overhead) (					4, 697, 592	
13. 00	Ratio of hospital-based RHC/FQHC services (		,			1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (f			no 21)		1, 699, 402	
15. 00	Parent provider overhead allocated to facil			116 31)		6, 194, 859	
16. 00		ity (See Institut	0113)			7, 894, 261	
17. 00							17.00
	,					7, 894, 261	
18 00						1,074,201	1 10.00
18. 00 19. 00		OHC services (Li	ne 13 v line 1	8)		7, 894, 261	19 00

Heal th	Financial Systems HENRY COUNTY MEMORI	IAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-0030	Peri od:	Worksheet M-3	
SERVI (	CES	Component CCN: 15-8520	From 01/01/2019 To 12/31/2019	Date/Time Pre	
-		Title XVIII	RHC I	5/18/2020 9: 30 Cost	<u>6 am</u>
		THE AVIII	KIIC I	COST	
				1. 00	
1 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES	Wi+ M 2 Lin- 20)		7 007 722	1 00
1. 00 2. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Cost of vaccines and their administration (from Wkst. M-4, li			7, 886, 633 350, 396	1
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	10)		7, 536, 237	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			26, 972	
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)			26, 972 279. 41	
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on		7. 00
			our cur a tr on	01 21 1111 2 (1)	
			Prior to Jan.	On or After	
			1 (Rate Period		
			1)	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	0.00	8. 00
9.00	Rate for Program covered visits (see instructions)		279. 41	279. 41	9. 00
40.00	CALCULATION OF SETTLEMENT			0.070	10.00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line	-	0	8, 070 2, 254, 839	1
12.00	Program covered visits for mental health services (from contra		0	2, 254, 659	1
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	14. 00
15.00	Graduate Medical Education Pass Through Cost (see instruction	· ·			15. 00
16. 00 16. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re	•	0	2, 254, 839 1, 388, 341	
16. 01	Total program preventive charges (see instructions) (from prov	•		331, 100	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			537, 748	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		1, 263, 006	16. 04
1/ 05	(Titles V and XIX see instructions.)			1 000 754	1/ 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	1, 800, 754 0	
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		138, 333	
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		183, 782	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			1, 800, 754	1
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		154, 626	1
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			1, 955, 380 0	1
23. 00	Adjusted reimbursable bad debts (see instructions)			0	1
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25.00	, , , ,			0	25. 00
25. 50				0	
	Demonstration payment adjustment amount before sequestration			0 1, 955, 380	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			39, 108	
26. 02				07, 100	1
27. 00	1			1, 641, 207	
	Tentative settlement (for contractor use only)	00 07 100		0	
29.00	Balance due component/program (line 26 minus lines 26.01, 26.0) Protested amounts (nonallowable cost report items) in accorda			275, 065 0	1
50.00	chapter 1, §115.2	nee with owe rub. 19-11,		U	] 30.00

	E	IAL HOODITAL		6.5. 040.4	2550 40
	Financial Systems HENRY COUNTY MEMORI ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0030	Period:	u of Form CMS-2 Worksheet M-3	2552-10
SERVIC		FI OVI del CCN. 15-0030	From 01/01/2019	WOLKSHEET M-3	
OLIVITO		Component CCN: 15-8525	To 12/31/2019		
		Title XVIII	RHC II	5/18/2020 9: 30 Cost	<u>6 am</u>
		I tre xviii	KHC II	COST	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	The state of the s		12, 591, 853	
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		809, 118	
3. 00 4. 00	Total allowable cost excluding vaccine (line 1 minus line 2)			11, 782, 735	3. 00 4. 00
5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		46, 376 0	5.00
6. 00	Total adjusted visits (line 4 plus line 5)	11116 7)		46, 376	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			254. 07	7. 00
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On on Afton	
			1 (Rate Period	On or After	
			1)	Peri od 2)	
			1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	0.00	
9. 00	Rate for Program covered visits (see instructions)		254. 07	254. 07	9. 00
10. 00	CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from	contractor records)	0	5, 556	10. 00
11. 00	Program cost excluding costs for mental health services (line		0	1, 411, 613	
12. 00	Program covered visits for mental health services (from contra	•	0	1, 411, 013	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	14.00
15. 00	Graduate Medical Education Pass Through Cost (see instruction	*			15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	1, 411, 613	
16. 01 16. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov	•		919, 313 171, 553	
16. 02	Total program preventive charges (see Histractions) (Homeprov Total program preventive costs ((line 16.02/line 16.01) times			263, 421	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	*		839, 538	
	(Titles V and XIX see instructions.)	,			
16. 05	Total program cost (see instructions)		0	1, 102, 959	
17. 00	Primary payer amounts	(6::-		00.770	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Troil contractor		98, 770	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		129, 784	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			1, 102, 959	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		86, 140	1
22. 00	Total reimbursable Program cost (line 20 plus line 21)	,,		1, 189, 099	
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	2)		0	
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	5)		0	25. 50 25. 99
26. 00	Net reimbursable amount (see instructions)			1, 189, 099	
26. 01	Sequestration adjustment (see instructions)			23, 782	
26. 02	, ,			0	26. 02
	Interim payments			1, 119, 338	
28. 00	Tentative settlement (for contractor use only)	00 07 100		0	28. 00
29. 00		•		45, 979 0	
30. 00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	IICE WITH CWS PUD. 13-11,			30.00
	1b 1. A		ı İ	ı	'

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-0030	Peri od: From 01/01/2019	Worksheet M-4
VACCINE COST		Component CCN: 15-8520		Date/Time Prepared: 5/18/2020 9:36 am
		Title XVIII	RHC I	Cost

				5/18/2020 9:36	o alli
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2, 841, 687	2, 841, 687	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota	l health care staff time	0. 001466	0. 005952	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lin	ne 1 x line 2)	4, 166	16, 914	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr	rom your records)	62, 167	52, 839	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	sline 4)	66, 333	69, 753	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshe	et M-1, col. 7, line 22)	3, 062, 972	3, 062, 972	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		4, 823, 661	4, 823, 661	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tot	al direct cost (line 5	0. 021656	0. 022773	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	104, 461	109, 849	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	170, 794	179, 602	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	506	2, 054	11. 00
12. 00	Cost per pneumococcal and influenza vaccine injection (line 10	)/line 11)	337. 54	87. 44	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	255	784	13.00
	benefi ci ari es				
14. 00	Program cost of pneumococcal and influenza vaccine and its (th	neir) administration	86, 073	68, 553	14.00
	(line 12 x line 13)				
15. 00		,		350, 396	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,				
16. 00	Total Program cost of pneumococcal and influenza vaccine and i			154, 626	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQF VACCINE COST	C PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-0030	Peri od: From 01/01/2019	Worksheet M-4
VACCINE COST		Component CCN: 15-8525	To 12/31/2019	Date/Time Prepared: 5/18/2020 9:36 am
		Title XVIII	RHC II	Cost

				3/ 10/ 2020 9. 30	J aiii
		Title XVIII	RHC II	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		4, 244, 817	4, 244, 817	1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota	I health care staff time	0. 003363	0. 004143	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lin	e 1 x line 2)	14, 275	17, 586	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr	om your records)	214, 636	55, 360	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	line 4)	228, 911	72, 946	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshe	et M-1, col. 7, line 22)	4, 697, 592	4, 697, 592	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		7, 894, 261	7, 894, 261	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tot	al direct cost (line 5	0. 048729	0. 015528	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	384, 679	122, 582	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	613, 590	195, 528	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	1, 747	2, 152	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10	/line 11)	351. 22	90. 86	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	126	461	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (th	eir) administration	44, 254	41, 886	14.00
	(line 12 x line 13)				
15. 00	Total cost of pneumococcal and influenza vaccine and its (thei	r) administration (sum		809, 118	15.00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,				
16. 00	Total Program cost of pneumococcal and influenza vaccine and i	ts (their)		86, 140	16.00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED	RHC/FQHC PROVI DER FOR	Provider CCN: 15-0030		Worksheet M-5
SERVICES RENDERED TO PROGRAM BENEFICIAR	RLES		From 01/01/2019	
		Component CCN: 15-8520	To 12/31/2019	Date/Time Prepared:
				5/18/2020 9:36 am

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  Provider to Program  Substituting the payments of the interim payment and the payment and the payment and the payment and the payment and the payment and the payment and the payment and the payment and the payment and payment a		Com	ponent CCN: 15-8520		Date/Time Prep 5/18/2020 9:36	
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 training period. If none, write 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 (1) Provider to Program (1) Provider to Program (1) Provider to Program (1) Provider to Program (1) Provider (2) Provider (3) Provider (4) Program (4) Provider (5) Provider (5) Provider (5) Provider (6) Provider (7) Provider						
Total interim payments paid to hospital-based RHC/FOHC   1,499,80   1,499,8				Par	t B	
Total interim payments paid to hospital-based RHC/FOHC 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  It is 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  O8/31/2019  141,400  08  141,400  151  162  163  164  175  185  185  185  185  185  185  185				mm/dd/yyyy	Amount	
1. 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  1. 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  1. Provider to Program  1. Provider to Program  1. Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  1. Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  1. Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)  1. Dist COMPLETED BY CONTRACTOR  1. 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  1. Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  1. Determined net settlement amount (balance due) based on the cost report. (1)  2. SETILEMENT TO PROVIDER  2. SETILEMENT TO PROVIDER  2. SETILEMENT TO PROVIDER  2. SETILEMENT TO PROVIDER  3. Number (Mo/Day/Yr).				1. 00	2. 00	
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  101 102 103 104 105 106 107 108 109 109 109 109 100 109 100 100 100 100	OO Total interim payments paid to hospital-b	pased RHC/FQHC			1, 499, 807	1. (
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  O8/31/2019 141, 400  O8/	OO Interim payments payable on individual bi	IIs, either submitted or	to be submitted to		0	2. (
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						
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  08/31/2019 141, 400 08/31/201	"NONE" or enter a zero	. 3.				
payment. If none, write "NONE" or enter a zero. (1) Program to Provider  01 02 03 08/31/2019 141, 400 06 06 06 06 06 06 06 06 06 06 06 06 0	OO List separately each retroactive lump sum	adjustment amount based	on subsequent			3.
Program to Provider  08/31/2019 141,400 06 07 08/31/2019 141,400 07 08/31/2019 141,400 08	revision of the interim rate for the cost	reporting period. Also	show date of each			
01 02 03 04 05 06 06 06 06 06 06 06 06 06 06 06 06 06						
01 02 03 04 05 05 06 06 06 06 06 06 06 06 06 06 06 06 06	Program to Provider					
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)  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 3.01-3.49 minus sum of lines 4.2 and 3.99) (transfer to Worksheet M-3, line 1,641,20)  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 PROVIDER  SETTLEMENT TO PROGRAM  O  Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)				08/31/2019	141, 400	3.
OR Provider to Program  Provider to Program  Provider to Program  OR Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  OR 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  OR SUBSTILLEMENT TO PROVIDER  SETTLEMENT TO PROGRAM  OR TOTAL Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  Number (Mo/Day/Yr)					0	3.
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)  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  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  SETTLEMENT TO PROVIDER  SETTLEMENT TO PROVIDER  SETTLEMENT TO PROGRAM  Total Medicare program liability (see instructions)  NPR Date (Mo/Day/Yrr)  Number (Mo/Day/Yrr)					o	3.
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)  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  Contractor Number (Mo/Day/Yrr)  Contractor Number (Mo/Day/Yrr)					0	3.
Provider to Program  (55) (56) (57) (58) (58) (58) (59) (50) (50) (50) (50) (50) (50) (50) (50					o o	3.
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  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  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 (Mc/Day/Yr)						٦.
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  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 NPR Date (No/Day/Yrr)  Number (Mo/Day/Yrr)	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 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  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/Yrr)					ol	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  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)					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  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 PROROHAM  Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)					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  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line  1, 641, 201  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line  1, 641, 201  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line  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  Frovider to Program  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	3.
Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line  1,641,207  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  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 NPR Date (Mo/Day/Yr)		<del></del>			ı	3.
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  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)			W I I I I I I I I I I I I I I I I I I I			
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  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)	1 3 1	, and 3.99) (transfer to	worksneet M-3, line		1, 641, 207	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  Provider to Program  Provider to Program  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  Contractor NPR Date (Mo/Day/Yr)						
each payment. If none, write "NONE" or enter a zero. (1) Program to Provider  Provider to Program  Provider to Program  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)		normant often dock roul	Al on obout data o	£		5.
Program to Provider  Provider to Program  Provider			ew. Also snow date o	'		) 5
Provider to Program  Provider to Program  Signature of the program		iter a zero. (1)				
Provider to Program  Provider to Program  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)	3				0	_
Provider to Program  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)					· ·	5
Provider to Program    Contractor Number (Mo/Day/Yr)   Provider to Program   Provider to Pro					0	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 Number (Mo/Day/Yr)						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 Number (Mo/Day/Yr)	3					_
2 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 Determined net settlement amount (balance due) based on the cost report. (1) 1 SETTLEMENT TO PROVIDER 2 SETTLEMENT TO PROGRAM 0 Total Medicare program liability (see instructions) 275,069 1,916,275 Contractor NPR Date (Mo/Day/Yr)					0	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)	l l				0	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)		6.11			0	5.
SETTLEMENT TO PROVIDER  SETTLEMENT TO PROGRAM  Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)					0	5.
22 SETTLEMENT TO PROGRAM 30 Total Medicare program liability (see instructions) 31,916,272 32 Contractor NPR Date (Mo/Day/Yr)	· ·	e due) based on the cost	report. (1)			6.
Total Medicare program liability (see instructions)  1,916,272  Contractor NPR Date (Mo/Day/Yr)						6.
Contractor NPR Date Number (Mo/Day/Yr)					0	6.
Number (Mo/Day/Yr)	00  Total Medicare program liability (see ins	structions)			1, 916, 272	7.
				Contractor	1 1 1	
0 1.00 2.00						
			0	1. 00	2. 00	
00 Name of Contractor	OO  Name of Contractor	1				8.

Health Financial Systems	HENRY COUNTY MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RH SERVICES RENDERED TO PROGRAM BENEFICIARIE		Provi der CCN: 15-0030	Peri od: From 01/01/2019	
		Component CCN: 15-8525	To 12/31/2019	Date/Time Prepared: 5/18/2020 9:36 am

		Component CCN: 15-8525	10 12/31/2019	5/18/2020 9: 30	
			RHC II	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			959, 538	1.00
2.00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero			0	2. 00
3.00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period.				3. 00
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider				
3. 01	Program to Provider		08/31/2019	159, 800	3.0
3. 02			00/31/2019	159, 800	3.0
3. 02				0	3. 0
3. 04				0	3.04
3. 05				0	3. 0
0.00	Provider to Program			Ü	0.0
3.50				0	3.5
3. 51				0	3.5
3. 52				0	3.5
3. 53				o	3. 5
3. 54				o	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		159, 800	3. 9
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)		:	1, 119, 338	4. 0
	TO BE COMPLETED BY CONTRACTOR		<u> </u>		
5.00	List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	f		5. 0
	Program to Provider				
5. 01				0	5. 0
5. 02				0	5.0
5. 03				0	5. C
	Provider to Program				
5. 50				0	5. 5
5. 51				0	5. 5
5. 52				0	5. 5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	,		0	5. 9
5. 00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.0
5. 01	SETTLEMENT TO PROVIDER			45, 979	6.0
6. 02	SETTLEMENT TO PROGRAM			0	6.0
7. 00	Total Medicare program liability (see instructions)			1, 165, 317	7. C
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
0.00	Name of Contractor	0	1. 00	2. 00	0.0
8.00	Name of Contractor				8.0