This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1331	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 6/28/2021 3:11 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/28/2021 Time: 3:11 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter 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 HARRISON COUNTY HOSPITAL (15-1331) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 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.

(Signed) CHARLES WILEY
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,552,359	1,006,920	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	186,349	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	1,738,708	1,006,920	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 6/28/2021 3:11 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1141 ATWOOD STREET	PO Box:			1.00
2.00	City: CORYDON	State: IN	Zip Code: 47112-	County: HARRISON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HARRISON COUNTY HOSPITAL	151331	31140	1	12/15/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HARRISON COUNTY SWING BEDS	15Z331	15999		08/14/2011	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2020	12/31/2020	20.00
21.00	Type of Control (see instructions)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for 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.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care 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.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to 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.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 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.	2	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 6/28/2021 3:11 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		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 with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
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				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 6/28/2021 3:11 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents 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)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 6/28/2021 3:11 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		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				
66.00	Enter in column 1 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)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 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)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	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 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)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1331	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 6/28/2021 3:11 pm

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		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	Y	109.00

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 6/28/2021 3:11 pm

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	457,013	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.01	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 6/28/2021 3:11 pm

	1.00	2.00	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	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for 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.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? 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.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	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	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		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 campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
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 transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in 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)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 6/28/2021 3:11 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	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)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N	16.00
17.00	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 in columns 2 and 4. (see instructions)	Y	04/01/2021	Y	04/01/2021 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
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.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 6/28/2021 3:11 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		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 (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CLINT		BRILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND COMPANY				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502.992.3512		CBRILL@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1331	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 6/28/2021 3:11 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 6/28/2021 3:11 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,686	77,904.00	0	1.00
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 beds) (see instructions)		21	7,686	77,904.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,464	10,176.00	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)		25	9,150	88,080.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 6/28/2021 3:11 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		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 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,325	67	3,246			1.00
2.00	HMO and other (see instructions)	590	819				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	225	0	225			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,550	67	3,471			7.00
8.00	INTENSIVE CARE UNIT	193	2	424			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		11	695			13.00
14.00	Total (see instructions)	1,743	80	4,590	0.00	499.15	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	499.15	27.00
28.00	Observation Bed Days		17	968			28.00
29.00	Ambulance Trips	1,843					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 6/28/2021 3:11 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	383	26	1,085	1.00
2.00	HMO and other (see instructions)			133	214		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 beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	383	26	1,085	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 6/28/2021 3:11 pm

		1.00	
	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)	0.274836	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,556,036	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	35,843,547	6.00
7.00	Medicaid cost (line 1 times line 6)	9,851,097	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,295,061	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 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 13; if < zero then enter zero)	0	16.00
	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 8, 12 and 16)	3,295,061	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	660,320	1,307,893	1,968,213	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	181,480	1,307,893	1,489,373	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	181,480	1,307,893	1,489,373	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,279,268	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	486,358	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	748,244	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,531,024	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,232,339	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,721,712	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,016,773	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,529,728	1,529,728	234,694	1,764,422	1.00
1.01	00101	MOB		658,330	658,330	0	658,330	1.01
1.02	00102	AMB DEPR		0	0	65,303	65,303	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,172,889	1,172,889	3,970	1,176,859	2.00
2.01	00201	AMB EQUIP		0	0	166,506	166,506	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	184,915	625,856	810,771	212,334	1,023,105	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	1,567,314	5,143,194	6,710,508	-1,796	6,708,712	5.01
5.02	00570	ADMITTING	477,069	157,923	634,992	0	634,992	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	416,065	718,467	1,134,532	0	1,134,532	5.03
7.00	00700	OPERATION OF PLANT	259,501	1,468,997	1,728,498	0	1,728,498	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,912	239,509	262,421	0	262,421	8.00
9.00	00900	HOUSEKEEPING	523,965	334,300	858,265	0	858,265	9.00
10.00	01000	DIETARY	439,969	446,358	886,327	-496,343	389,984	10.00
11.00	01100	CAFETERIA	0	0	0	496,343	496,343	11.00
13.00	01300	NURSING ADMINISTRATION	665,564	199,730	865,294	0	865,294	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	218,166	2,673,487	2,891,653	-2,054,547	837,106	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	608,410	308,709	917,119	-75	917,044	16.00
17.00	01700	SOCIAL SERVICE	383,794	88,830	472,624	0	472,624	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,240,653	1,628,231	5,868,884	-174,926	5,693,958	30.00
31.00	03100	INTENSIVE CARE UNIT	346,060	116,405	462,465	-1,277	461,188	31.00
43.00	04300	NURSERY	0	145	145	140,581	140,726	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	977,744	794,099	1,771,843	-225,807	1,546,036	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,103,385	1,103,385	-18,924	1,084,461	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	997,885	1,006,133	2,004,018	-73,548	1,930,470	54.00
60.00	06000	LABORATORY	808,139	1,688,575	2,496,714	-181,262	2,315,452	60.00
65.00	06500	RESPIRATORY THERAPY	0	547,029	547,029	-37,190	509,839	65.00
66.00	06600	PHYSICAL THERAPY	356,719	76,539	433,258	-65,595	367,663	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	193	193	60,829	61,022	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,766	4,766	68.00
69.00	06900	ELECTROCARDIOLOGY	422,402	168,903	591,305	12,254	603,559	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,785,966	1,785,966	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,303,624	1,303,624	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	352,052	2,518,489	2,870,541	-6,243	2,864,298	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,172	55,080	74,252	-12,612	61,640	90.00
90.01	09001	SENIOR CARE	98,506	154,842	253,348	-14	253,334	90.01
90.02	09002	GENERAL SURGERY	869,597	276,939	1,146,536	-1,627	1,144,909	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	571,076	291,339	862,415	-30,932	831,483	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	514,222	243,491	757,713	-29,486	728,227	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	1,208,786	633,401	1,842,187	-374,984	1,467,203	90.05
90.06	09006	OBGYN - DR SAUER	495,052	207,284	702,336	-5,114	697,222	90.06
91.00	09100	EMERGENCY	1,572,653	959,489	2,532,142	-13,865	2,518,277	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,231,383	1,463,802	3,695,185	-417,202	3,277,983	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		204,950	204,950	-204,950	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,849,745	29,905,050	51,754,795	58,851	51,813,646	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,287,340	3,368,177	8,655,517	-58,851	8,596,666	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	416,798	240,944	657,742	0	657,742	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	27,553,883	33,514,171	61,068,054	0	61,068,054	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-22,438	1,741,984		1.00
1.01	00101	MOB	0	658,330		1.01
1.02	00102	AMB DEPR	0	65,303		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	1,176,859		2.00
2.01	00201	AMB EQUIP	0	166,506		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-43,329	979,776		4.00
5.01	00590	ADMINISTRATIVE & GENERAL	-1,521,600	5,187,112		5.01
5.02	00570	ADMITTING	0	634,992		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,134,532		5.03
7.00	00700	OPERATION OF PLANT	0	1,728,498		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	262,421		8.00
9.00	00900	HOUSEKEEPING	0	858,265		9.00
10.00	01000	DIETARY	0	389,984		10.00
11.00	01100	CAFETERIA	-123,850	372,493		11.00
13.00	01300	NURSING ADMINISTRATION	0	865,294		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	837,106		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,821	903,223		16.00
17.00	01700	SOCIAL SERVICE	0	472,624		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	5,693,958		30.00
31.00	03100	INTENSIVE CARE UNIT	0	461,188		31.00
43.00	04300	NURSERY	0	140,726		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,546,036		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-1,073,500	10,961		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,930,470		54.00
60.00	06000	LABORATORY	-5,460	2,309,992		60.00
65.00	06500	RESPIRATORY THERAPY	-3,035	506,804		65.00
66.00	06600	PHYSICAL THERAPY	0	367,663		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	61,022		67.00
68.00	06800	SPEECH PATHOLOGY	0	4,766		68.00
69.00	06900	ELECTROCARDIOLOGY	0	603,559		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,785,966		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,303,624		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,864,298		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	61,640		90.00
90.01	09001	SENIOR CARE	0	253,334		90.01
90.02	09002	GENERAL SURGERY	-875,488	269,421		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	-396,604	434,879		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	-434,189	294,038		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	-1,134,660	332,543		90.05
90.06	09006	OBGYN - DR SAUER	-555,909	141,313		90.06
91.00	09100	EMERGENCY	0	2,518,277		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-13,887	3,264,096		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,217,770	45,595,876		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,596,666		192.00
194.00	07950	MARKETING	0	0		194.00
194.01	07951	PHYSICIAN BILLING	0	657,742		194.01
194.02	07952	MOB	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,217,770	54,850,284		200.00

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 6/28/2021 3:11 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,089,590		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
	0		0	3,089,590		
	B - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,303,624		1.00
	0		0	1,303,624		
	C - AMBULANCE CAPITAL					
1.00	AMB DEPR	1.02	0	65,303		1.00
2.00	AMB EQUIP	2.01	0	166,506		2.00
	0		0	231,809		
	D - INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	204,950		1.00
	0		0	204,950		
	E - EKG					
1.00	ELECTROCARDIOLOGY	69.00	13,347	18,194		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		13,347	18,194		
	F - NURSERY					
1.00	NURSERY	43.00	140,592	0		1.00
	0		140,592	0		
	G - THERAPY					
1.00	SPEECH PATHOLOGY	68.00	3,924	842		1.00
2.00	OCCUPATIONAL THERAPY	67.00	50,083	10,746		2.00
	0		54,007	11,588		
	H - CAFETERIA					
1.00	CAFETERIA	11.00	246,383	249,960		1.00
	0		246,383	249,960		
	I - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	29,744		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,970		2.00
	TOTALS		0	33,714		
	J - AMBULANCE WORKERS COMP					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	185,326		1.00
	TOTALS		0	185,326		
	K - MISCELLANEOUS BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	27,008		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	27,008		
500.00	Grand Total: Increases		454,329	5,355,763		500.00

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 6/28/2021 3:11 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,054,547	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	34,334	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	1,277	0		3.00
4.00	NURSERY	43.00	0	11	0		4.00
5.00	OPERATING ROOM	50.00	0	225,807	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	18,924	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	73,548	0		7.00
8.00	LABORATORY	60.00	0	168,488	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	18,996	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	19,287	0		10.00
11.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,243	0		11.00
12.00	CLINIC	90.00	0	12,612	0		12.00
13.00	SENIOR CARE	90.01	0	14	0		13.00
14.00	GENERAL SURGERY	90.02	0	1,627	0		14.00
15.00	HARRISON CRAWFORD HEALTHCARE	90.03	0	30,932	0		15.00
16.00	CORYDON MEDICAL ASSOCIATES	90.04	0	29,486	0		16.00
17.00	ORTHOPEDIC SURGERY - DR KLINE	90.05	0	374,984	0		17.00
18.00	OBGYN - DR SAUER	90.06	0	5,114	0		18.00
19.00	EMERGENCY	91.00	0	13,359	0		19.00
	0		0	3,089,590			
	B - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,303,624	0		1.00
	0		0	1,303,624			
	C - AMBULANCE CAPITAL						
1.00	AMBULANCE SERVICES	95.00	0	231,809	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	231,809			
	D - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	204,950	11		1.00
	0		0	204,950			
	E - EKG						
1.00		0.00	0	0	0		1.00
2.00	LABORATORY	60.00	12,774	0	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	18,194	0		3.00
4.00	EMERGENCY	91.00	506	0	0		4.00
5.00	AMBULANCE SERVICES	95.00	67	0	0		5.00
	0		13,347	18,194			
	F - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	140,592	0	0		1.00
	0		140,592	0			
	G - THERAPY						
1.00	PHYSICAL THERAPY	66.00	54,007	11,588	0		1.00
2.00		0.00	0	0	0		2.00
	0		54,007	11,588			
	H - CAFETERIA						
1.00	DIETARY	10.00	246,383	249,960	0		1.00
	0		246,383	249,960			
	I - DEPRECIATION RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	33,714	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	33,714			
	J - AMBULANCE WORKERS COMP						
1.00	AMBULANCE SERVICES	95.00	0	185,326	0		1.00
	TOTALS		0	185,326			
	K - MISCELLANEOUS BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.01	0	1,796	0		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	75	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	25,137	0		3.00
	TOTALS		0	27,008			
500.00	Grand Total: Decreases		454,329	5,355,763			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 6/28/2021 3:11 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,001,138	0	0	0	0	1.00
2.00	Land Improvements	3,379,433	0	0	0	0	2.00
3.00	Buildings and Fixtures	41,594,545	21,104	0	21,104	0	3.00
4.00	Building Improvements	3,605,135	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	28,141,853	567,399	0	567,399	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	79,722,104	588,503	0	588,503	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	79,722,104	588,503	0	588,503	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,001,138	0	1.00
2.00	Land Improvements	3,379,433	0	2.00
3.00	Buildings and Fixtures	41,615,649	0	3.00
4.00	Building Improvements	3,605,135	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	28,709,252	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	80,310,607	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	80,310,607	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 6/28/2021 3:11 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,426,759	0	0	102,969	0	1.00
1.01	MOB	283,170	74,983	83,828	0	0	1.01
1.02	AMB DEPR	0	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,172,889	0	0	0	0	2.00
2.01	AMB EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,882,818	74,983	83,828	102,969	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,529,728		1.00
1.01	MOB	216,349	658,330		1.01
1.02	AMB DEPR	0	0		1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,172,889		2.00
2.01	AMB EQUIP	0	0		2.01
3.00	Total (sum of lines 1-2)	216,349	3,360,947		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 6/28/2021 3:11 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	51,601,355	0	51,601,355	0.642522	0	1.00
1.01	MOB	0	0	0	0.000000	0	1.01
1.02	AMB DEPR	0	0	0	0.000000	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	28,709,252	0	28,709,252	0.357478	0	2.00
2.01	AMB EQUIP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	80,310,607	0	80,310,607	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,456,503	0	1.00
1.01	MOB	0	0	0	283,170	74,983	1.01
1.02	AMB DEPR	0	0	0	65,303	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,176,859	0	2.00
2.01	AMB EQUIP	0	0	0	166,506	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	3,148,341	74,983	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	182,512	102,969	0	0	1,741,984	1.00
1.01	MOB	83,828	0	0	216,349	658,330	1.01
1.02	AMB DEPR	0	0	0	0	65,303	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,176,859	2.00
2.01	AMB EQUIP	0	0	0	0	166,506	2.01
3.00	Total (sum of lines 1-2)	266,340	102,969	0	216,349	3,808,982	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 6/28/2021 3:11 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - MOB (chapter 2)		0	MOB	1.01	0	1.01
1.02	Investment income - AMB DEPR (chapter 2)		0	AMB DEPR	1.02	0	1.02
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - AMB EQUIP (chapter 2)		0	AMB EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,015	ADMINISTRATIVE & GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,835,043			0	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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-123,850	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-13,821	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - MOB		0	MOB	1.01	0	26.01
26.02	Depreciation - AMB DEPR		0	AMB DEPR	1.02	0	26.02
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - AMB EQUIP		0	AMB EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 6/28/2021 3:11 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME - A&G	B	-42,429	ADMINISTRATIVE & GENERAL	5.01	0	33.00
33.01	MISC INCOME - LABORATORY	B	-2,287	LABORATORY	60.00	0	33.01
33.02	CLINIC RENT	B	-64,833	GENERAL SURGERY	90.02	0	33.02
33.03	CLINIC RENT	B	-76,972	HARRISON CRAWFORD HEALTHCARE	90.03	0	33.03
33.04	CLINIC RENT	B	-67,918	CORYDON MEDICAL ASSOCIATES	90.04	0	33.04
33.05	CLINIC RENT	B	-57,769	ORTHOPEDIC SURGERY - DR KLINE	90.05	0	33.05
33.06	CLINIC RENT	B	-38,953	OBGYN - DR SAUER	90.06	0	33.06
33.07	FOUNDATION SALARY	B	-31,640	ADMINISTRATIVE & GENERAL	5.01	0	33.07
33.08	INTEREST	B	-13,778	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.08
33.09	PROVIDER TAX FEE	A	-1,307,198	ADMINISTRATIVE & GENERAL	5.01	0	33.09
33.10	UNNECESSARY BORROWING	A	-8,660	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.10
34.00	CRNA	A	-1,073,500	ANESTHESIOLOGY	53.00	0	34.00
35.00	LOBBYING FEES	A	-5,946	ADMINISTRATIVE & GENERAL	5.01	0	35.00
36.00	MARKETING EXPENSE	A	-131,372	ADMINISTRATIVE & GENERAL	5.01	0	36.00
37.00	NURSE PRACTITIONER OFFSET - SALARY	A	-80,735	HARRISON CRAWFORD HEALTHCARE	90.03	0	37.00
38.00	NURSE PRACTITIONER OFFSET - SALARY	A	-104,572	CORYDON MEDICAL ASSOCIATES	90.04	0	38.00
39.00	NURSE PRACTITIONER OFFSET - SALARY	A	-90,150	ORTHOPEDIC SURGERY - DR KLINE	90.05	0	39.00
40.00	NURSE PRACTITIONER OFFSET - BENEFITS	A	-43,329	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,217,770				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 6/28/2021 3:11 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	17.00	SOCIAL SERVICE	109,381	0	109,381	0	0	1.00
2.00	60.00	LABORATORY	31,730	3,173	28,557	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	3,035	3,035	0	0	0	3.00
4.00	90.02	GENERAL SURGERY	835,151	810,655	24,496	0	0	4.00
5.00	90.03	HARRISON CRAWFORD HEALTHCARE	250,915	238,897	12,018	0	0	5.00
6.00	90.04	CORYDON MEDICAL ASSOCIATES	261,699	261,699	0	0	0	6.00
7.00	90.05	ORTHOPEDIC SURGERY - DR KLINE	1,020,702	986,741	33,961	0	0	7.00
8.00	90.06	OBGYN - DR SAUER	516,956	516,956	0	0	0	8.00
9.00	91.00	EMERGENCY	458,248	0	458,248	0	0	9.00
10.00	95.00	AMBULANCE SERVICES	13,887	13,887	0	0	0	10.00
200.00			3,501,704	2,835,043	666,661		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	17.00	SOCIAL SERVICE	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	90.02	GENERAL SURGERY	0	0	0	0	0	4.00
5.00	90.03	HARRISON CRAWFORD HEALTHCARE	0	0	0	0	0	5.00
6.00	90.04	CORYDON MEDICAL ASSOCIATES	0	0	0	0	0	6.00
7.00	90.05	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	0	0	7.00
8.00	90.06	OBGYN - DR SAUER	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	17.00	SOCIAL SERVICE	0	0	0	0		1.00
2.00	60.00	LABORATORY	0	0	0	3,173		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	3,035		3.00
4.00	90.02	GENERAL SURGERY	0	0	0	810,655		4.00
5.00	90.03	HARRISON CRAWFORD HEALTHCARE	0	0	0	238,897		5.00
6.00	90.04	CORYDON MEDICAL ASSOCIATES	0	0	0	261,699		6.00
7.00	90.05	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	986,741		7.00
8.00	90.06	OBGYN - DR SAUER	0	0	0	516,956		8.00
9.00	91.00	EMERGENCY	0	0	0	0		9.00
10.00	95.00	AMBULANCE SERVICES	0	0	0	13,887		10.00
200.00			0	0	0	2,835,043		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1331	Period: From 01/01/2020 To 12/31/2020	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/28/2021 3:11 pm

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.50	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	8,760.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	67.13	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.57	33.57	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	588,059	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	588,059	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	588,059	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	588,059	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 6/28/2021 3:11 pm

		Respiratory Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.13	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		588,059	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		588,059	63.00
64.00	Total cost of outside supplier services (from your records)		482,036	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,741,984	1,741,984				1.00
1.01	00101	MOB	658,330	0	658,330			1.01
1.02	00102	AMB DEPR	65,303	0	0	65,303		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,176,859				1,176,859	2.00
2.01	00201	AMB EQUIP	166,506				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	979,776	2,554	0	0	1,725	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	5,187,112	256,778	3,765	0	173,476	5.01
5.02	00570	ADMITTING	634,992	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,134,532	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	1,728,498	200,305	0	0	135,323	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	262,421	11,696	0	0	7,901	8.00
9.00	00900	HOUSEKEEPING	858,265	25,051	0	0	16,924	9.00
10.00	01000	DIETARY	389,984	72,893	0	0	49,245	10.00
11.00	01100	CAFETERIA	372,493	36,414	0	0	24,601	11.00
13.00	01300	NURSING ADMINISTRATION	865,294	6,129	0	0	4,140	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	837,106	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	903,223	40,666	21,956	0	27,474	16.00
17.00	01700	SOCIAL SERVICE	472,624	2,451	0	0	1,656	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,693,958	296,257	0	0	200,149	30.00
31.00	03100	INTENSIVE CARE UNIT	461,188	36,989	0	0	24,989	31.00
43.00	04300	NURSERY	140,726	7,661	0	0	5,176	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,546,036	226,275	0	0	152,868	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	10,961	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,930,470	118,551	0	0	80,092	54.00
60.00	06000	LABORATORY	2,309,992	62,308	0	0	42,094	60.00
65.00	06500	RESPIRATORY THERAPY	506,804	13,560	0	0	9,161	65.00
66.00	06600	PHYSICAL THERAPY	367,663	45,876	0	0	30,993	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,022	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,766	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	603,559	23,289	0	0	15,734	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,785,966	55,618	0	0	37,574	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,303,624	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,864,298	15,654	0	0	10,575	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	61,640	0	30,985	0	0	90.00
90.01	09001	SENIOR CARE	253,334	0	22,475	0	0	90.01
90.02	09002	GENERAL SURGERY	269,421	0	43,414	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	434,879	0	60,664	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	294,038	0	60,664	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	332,543	0	92,801	0	0	90.05
90.06	09006	OBGYN - DR SAUER	141,313	0	30,332	0	0	90.06
91.00	09100	EMERGENCY	2,518,277	83,746	30,985	0	56,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,264,096	0	0	65,303	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,595,876	1,640,721	398,041	65,303	1,108,447	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,406	0	0	7,030	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,596,666	84,473	0	0	57,069	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	657,742	6,384	0	0	4,313	194.01
194.02	07952	MOB	0	0	260,289	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	54,850,284	1,741,984	658,330	65,303	1,176,859	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	ADMITTING	
			2.01	4.00	4A	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP	166,506					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	984,055				4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	56,353	5,677,484	5,677,484		5.01
5.02	00570	ADMITTING	0	17,153	652,145	75,297	727,442	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	14,960	1,149,492	132,720	0	5.03
7.00	00700	OPERATION OF PLANT	0	9,330	2,073,456	239,401	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	824	282,842	32,657	0	8.00
9.00	00900	HOUSEKEEPING	0	18,839	919,079	106,117	0	9.00
10.00	01000	DIETARY	0	6,960	519,082	59,933	0	10.00
11.00	01100	CAFETERIA	0	8,859	442,367	51,076	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,930	899,493	103,855	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,844	844,950	97,558	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,875	1,015,194	117,214	0	16.00
17.00	01700	SOCIAL SERVICE	0	13,799	490,530	56,637	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	147,418	6,337,782	731,760	42,818	30.00
31.00	03100	INTENSIVE CARE UNIT	0	12,443	535,609	61,841	5,438	31.00
43.00	04300	NURSERY	0	5,055	158,618	18,314	6,275	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	35,155	1,960,334	226,340	62,343	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	10,961	1,266	12,343	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,879	2,164,992	249,970	165,344	54.00
60.00	06000	LABORATORY	0	28,597	2,442,991	282,068	115,708	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	529,525	61,139	12,638	65.00
66.00	06600	PHYSICAL THERAPY	0	10,884	455,416	52,582	11,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,801	62,823	7,254	2,017	67.00
68.00	06800	SPEECH PATHOLOGY	0	141	4,907	567	499	68.00
69.00	06900	ELECTROCARDIOLOGY	0	15,667	658,249	76,001	39,958	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,879,158	216,968	22,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,303,624	150,516	18,891	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,658	2,903,185	335,202	44,000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	689	93,314	10,774	912	90.00
90.01	09001	SENIOR CARE	0	3,542	279,351	32,254	1,420	90.01
90.02	09002	GENERAL SURGERY	0	31,266	344,101	39,730	502	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	20,533	516,076	59,586	3,028	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	18,489	373,191	43,089	3,757	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	43,462	468,806	54,128	3,113	90.05
90.06	09006	OBGYN - DR SAUER	0	17,800	189,445	21,873	680	90.06
91.00	09100	EMERGENCY	0	56,527	2,746,112	317,066	107,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	166,506	80,227	3,576,132	412,900	44,575	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	166,506	778,959	44,960,816	4,535,653	727,442	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17,436	2,013	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	190,110	8,928,318	1,030,857	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	14,986	683,425	78,908	0	194.01
194.02	07952	MOB	0	0	260,289	30,053	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	166,506	984,055	54,850,284	5,677,484	727,442	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.03	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,282,212					5.03
7.00	00700	OPERATION OF PLANT	0	2,312,857				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,094	336,593			8.00
9.00	00900	HOUSEKEEPING	0	45,182	0	1,070,378		9.00
10.00	01000	DIETARY	0	131,470	4,109	62,639	777,233	10.00
11.00	01100	CAFETERIA	0	65,678	0	31,292	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,054	0	5,267	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	73,346	0	34,946	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,421	0	2,107	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75,476	534,335	105,598	254,580	687,438	30.00
31.00	03100	INTENSIVE CARE UNIT	9,586	66,714	37,225	31,786	89,795	31.00
43.00	04300	NURSERY	11,062	13,817	0	6,583	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	109,893	408,113	23,231	194,445	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	21,757	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	291,388	213,821	42,616	101,874	0	54.00
60.00	06000	LABORATORY	203,961	112,380	0	53,543	0	60.00
65.00	06500	RESPIRATORY THERAPY	22,277	24,456	0	11,652	0	65.00
66.00	06600	PHYSICAL THERAPY	19,503	82,742	0	39,422	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,555	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	879	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	70,436	42,004	5,015	20,013	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,503	100,313	0	47,794	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	33,299	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,560	28,233	0	13,452	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,608	0	760	0	0	90.00
90.01	09001	SENIOR CARE	2,503	0	91	0	0	90.01
90.02	09002	GENERAL SURGERY	885	0	366	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	5,337	0	0	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	6,622	0	324	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	5,488	0	110	0	0	90.05
90.06	09006	OBGYN - DR SAUER	1,198	0	723	0	0	90.06
91.00	09100	EMERGENCY	188,863	151,045	89,455	71,965	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	78,573	0	16,289	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,282,212	2,130,218	325,912	983,360	777,233	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,768	0	8,942	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	152,357	10,681	72,590	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	11,514	0	5,486	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,282,212	2,312,857	336,593	1,070,378	777,233	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	590,413					11.00
13.00	01300	NURSING ADMINISTRATION	17,262	1,036,931				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,624	0	955,132			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,558	0	3,212	1,272,470		16.00
17.00	01700	SOCIAL SERVICE	9,391	0	165	0	563,251	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	159,027	542,663	42,986	74,908	418,858	30.00
31.00	03100	INTENSIVE CARE UNIT	14,529	49,578	4,732	9,514	54,712	31.00
43.00	04300	NURSERY	5,792	19,765	23	10,979	89,681	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,415	154,972	64,856	109,066	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	4,162	21,593	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,683	0	28,283	289,102	0	54.00
60.00	06000	LABORATORY	30,097	0	164,590	202,426	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	4,802	22,110	0	65.00
66.00	06600	PHYSICAL THERAPY	8,756	0	595	19,356	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,443	0	31	3,528	0	67.00
68.00	06800	SPEECH PATHOLOGY	115	0	0	872	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14,356	48,987	6,467	69,906	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	291,286	40,198	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	206,407	33,049	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,389	0	2,269	76,977	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	693	2,364	2,051	1,596	0	90.00
90.01	09001	SENIOR CARE	2,867	9,784	106	2,484	0	90.01
90.02	09002	GENERAL SURGERY	10,911	0	898	878	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	18,031	0	7,025	5,297	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	14,221	0	6,834	6,572	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	19,244	0	62,295	5,447	0	90.05
90.06	09006	OBGYN - DR SAUER	5,850	0	4,515	1,189	0	90.06
91.00	09100	EMERGENCY	61,195	208,818	18,416	187,441	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	28,126	77,982	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	530,449	1,036,931	955,132	1,272,470	563,251	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,276	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	21,688	0	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	590,413	1,036,931	955,132	1,272,470	563,251	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	AMB DEPR					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	AMB EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE & GENERAL					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	10,008,229	0	10,008,229		30.00
31.00	03100	INTENSIVE CARE UNIT	971,059	0	971,059		31.00
43.00	04300	NURSERY	340,909	0	340,909		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,359,008	0	3,359,008		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	72,082	0	72,082		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,591,073	0	3,591,073		54.00
60.00	06000	LABORATORY	3,607,764	0	3,607,764		60.00
65.00	06500	RESPIRATORY THERAPY	688,599	0	688,599		65.00
66.00	06600	PHYSICAL THERAPY	689,436	0	689,436		66.00
67.00	06700	OCCUPATIONAL THERAPY	80,651	0	80,651		67.00
68.00	06800	SPEECH PATHOLOGY	7,839	0	7,839		68.00
69.00	06900	ELECTROCARDIOLOGY	1,051,392	0	1,051,392		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,639,197	0	2,639,197		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,745,786	0	1,745,786		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,487,267	0	3,487,267		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	114,072	0	114,072		90.00
90.01	09001	SENIOR CARE	330,860	0	330,860		90.01
90.02	09002	GENERAL SURGERY	398,271	0	398,271		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	614,380	0	614,380		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	454,610	0	454,610		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	618,631	0	618,631		90.05
90.06	09006	OBGYN - DR SAUER	225,473	0	225,473		90.06
91.00	09100	EMERGENCY	4,147,518	0	4,147,518		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	4,234,577	0	4,234,577		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,478,683	0	43,478,683		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	47,159	0	47,159		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,233,079	0	10,233,079		192.00
194.00	07950	MARKETING	0	0	0		194.00
194.01	07951	PHYSICIAN BILLING	801,021	0	801,021		194.01
194.02	07952	MOB	290,342	0	290,342		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	54,850,284	0	54,850,284		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,554	0	0	1,725	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	256,778	3,765	0	173,476	5.01
5.02	00570	ADMITTING	0	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	200,305	0	0	135,323	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,696	0	0	7,901	8.00
9.00	00900	HOUSEKEEPING	0	25,051	0	0	16,924	9.00
10.00	01000	DIETARY	0	72,893	0	0	49,245	10.00
11.00	01100	CAFETERIA	0	36,414	0	0	24,601	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,129	0	0	4,140	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,666	21,956	0	27,474	16.00
17.00	01700	SOCIAL SERVICE	0	2,451	0	0	1,656	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	296,257	0	0	200,149	30.00
31.00	03100	INTENSIVE CARE UNIT	0	36,989	0	0	24,989	31.00
43.00	04300	NURSERY	0	7,661	0	0	5,176	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	226,275	0	0	152,868	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	118,551	0	0	80,092	54.00
60.00	06000	LABORATORY	0	62,308	0	0	42,094	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,560	0	0	9,161	65.00
66.00	06600	PHYSICAL THERAPY	0	45,876	0	0	30,993	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	23,289	0	0	15,734	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55,618	0	0	37,574	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,654	0	0	10,575	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	30,985	0	0	90.00
90.01	09001	SENIOR CARE	0	0	22,475	0	0	90.01
90.02	09002	GENERAL SURGERY	0	0	43,414	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	0	60,664	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	0	60,664	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	0	92,801	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0	0	30,332	0	0	90.06
91.00	09100	EMERGENCY	0	83,746	30,985	0	56,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	65,303	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,640,721	398,041	65,303	1,108,447	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,406	0	0	7,030	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	84,473	0	0	57,069	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	6,384	0	0	4,313	194.01
194.02	07952	MOB	0	0	260,289	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,741,984	658,330	65,303	1,176,859	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	ADMITTING	
			2.01	2A	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,279	4,279			4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	434,019	245	434,264		5.01
5.02	00570	ADMITTING	0	0	74	5,759	5,833	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	65	10,151	0	5.03
7.00	00700	OPERATION OF PLANT	0	335,628	40	18,311	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,597	4	2,498	0	8.00
9.00	00900	HOUSEKEEPING	0	41,975	82	8,116	0	9.00
10.00	01000	DIETARY	0	122,138	30	4,584	0	10.00
11.00	01100	CAFETERIA	0	61,015	38	3,907	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,269	104	7,943	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	34	7,462	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	90,096	95	8,965	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,107	60	4,332	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	496,406	640	55,969	345	30.00
31.00	03100	INTENSIVE CARE UNIT	0	61,978	54	4,730	44	31.00
43.00	04300	NURSERY	0	12,837	22	1,401	50	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	379,143	153	17,312	502	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	97	99	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	198,643	156	19,119	1,311	54.00
60.00	06000	LABORATORY	0	104,402	124	21,574	931	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,721	0	4,676	102	65.00
66.00	06600	PHYSICAL THERAPY	0	76,869	47	4,022	89	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	8	555	16	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1	43	4	68.00
69.00	06900	ELECTROCARDIOLOGY	0	39,023	68	5,813	322	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	93,192	0	16,595	185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	11,512	152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,229	55	25,638	354	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	30,985	3	824	7	90.00
90.01	09001	SENIOR CARE	0	22,475	15	2,467	11	90.01
90.02	09002	GENERAL SURGERY	0	43,414	136	3,039	4	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	60,664	89	4,557	24	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	60,664	80	3,296	30	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	92,801	189	4,140	25	90.05
90.06	09006	OBGYN - DR SAUER	0	30,332	77	1,673	5	90.06
91.00	09100	EMERGENCY	0	171,308	245	24,251	862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	166,506	231,809	348	31,581	359	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	166,506	3,379,018	3,381	346,912	5,833	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,436	0	154	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	141,542	833	78,864	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	10,697	65	6,035	0	194.01
194.02	07952	MOB	0	260,289	0	2,299	0	194.02
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	166,506	3,808,982	4,279	434,264	5,833	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.03	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	10,216					5.03
7.00	00700	OPERATION OF PLANT	0	353,979				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,228	25,327			8.00
9.00	00900	HOUSEKEEPING	0	6,915	0	57,088		9.00
10.00	01000	DIETARY	0	20,121	309	3,341	150,523	10.00
11.00	01100	CAFETERIA	0	10,052	0	1,669	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,692	0	281	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,226	0	1,864	0	16.00
17.00	01700	SOCIAL SERVICE	0	677	0	112	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	605	81,778	7,946	13,578	133,133	30.00
31.00	03100	INTENSIVE CARE UNIT	77	10,210	2,801	1,695	17,390	31.00
43.00	04300	NURSERY	89	2,115	0	351	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	881	62,461	1,748	10,371	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	174	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,269	32,725	3,207	5,433	0	54.00
60.00	06000	LABORATORY	1,636	17,200	0	2,856	0	60.00
65.00	06500	RESPIRATORY THERAPY	179	3,743	0	621	0	65.00
66.00	06600	PHYSICAL THERAPY	156	12,664	0	2,103	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	29	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	7	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	565	6,429	377	1,067	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	325	15,353	0	2,549	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	267	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	622	4,321	0	717	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13	0	57	0	0	90.00
90.01	09001	SENIOR CARE	20	0	7	0	0	90.01
90.02	09002	GENERAL SURGERY	7	0	28	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	43	0	0	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	53	0	24	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	44	0	8	0	0	90.05
90.06	09006	OBGYN - DR SAUER	10	0	54	0	0	90.06
91.00	09100	EMERGENCY	1,515	23,117	6,731	3,838	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	630	0	1,226	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,216	326,027	24,523	52,446	150,523	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,872	0	477	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	23,318	804	3,872	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	1,762	0	293	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,216	353,979	25,327	57,088	150,523	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	76,681					11.00
13.00	01300	NURSING ADMINISTRATION	2,242	22,531				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,640	0	9,136			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,709	0	31	115,986		16.00
17.00	01700	SOCIAL SERVICE	1,220	0	2	0	10,510	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,655	11,793	411	6,826	7,816	30.00
31.00	03100	INTENSIVE CARE UNIT	1,887	1,077	45	867	1,021	31.00
43.00	04300	NURSERY	752	429	0	1,000	1,673	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,898	3,367	620	9,939	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	40	1,968	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,673	0	270	26,379	0	54.00
60.00	06000	LABORATORY	3,909	0	1,574	18,446	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	46	2,015	0	65.00
66.00	06600	PHYSICAL THERAPY	1,137	0	6	1,764	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	187	0	0	321	0	67.00
68.00	06800	SPEECH PATHOLOGY	15	0	0	79	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,864	1,064	62	6,370	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,787	3,663	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,974	3,012	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	830	0	22	7,014	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	90	51	20	145	0	90.00
90.01	09001	SENIOR CARE	372	213	1	226	0	90.01
90.02	09002	GENERAL SURGERY	1,417	0	9	80	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	2,342	0	67	483	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	1,847	0	65	599	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	2,499	0	596	496	0	90.05
90.06	09006	OBGYN - DR SAUER	760	0	43	108	0	90.06
91.00	09100	EMERGENCY	7,948	4,537	176	17,080	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	269	7,106	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,893	22,531	9,136	115,986	10,510	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,971	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	2,817	0	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	76,681	22,531	9,136	115,986	10,510	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	AMB DEPR					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	AMB EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE & GENERAL					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	837,901	0	837,901		30.00
31.00	03100	INTENSIVE CARE UNIT	103,876	0	103,876		31.00
43.00	04300	NURSERY	20,719	0	20,719		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	492,395	0	492,395		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	2,378	0	2,378		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	295,185	0	295,185		54.00
60.00	06000	LABORATORY	172,652	0	172,652		60.00
65.00	06500	RESPIRATORY THERAPY	34,103	0	34,103		65.00
66.00	06600	PHYSICAL THERAPY	98,857	0	98,857		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,116	0	1,116		67.00
68.00	06800	SPEECH PATHOLOGY	149	0	149		68.00
69.00	06900	ELECTROCARDIOLOGY	63,024	0	63,024		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	134,649	0	134,649		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,917	0	16,917		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,802	0	65,802		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	32,195	0	32,195		90.00
90.01	09001	SENIOR CARE	25,807	0	25,807		90.01
90.02	09002	GENERAL SURGERY	48,134	0	48,134		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	68,269	0	68,269		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	66,658	0	66,658		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	100,798	0	100,798		90.05
90.06	09006	OBGYN - DR SAUER	33,062	0	33,062		90.06
91.00	09100	EMERGENCY	261,608	0	261,608		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	273,328	0	273,328		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,249,582	0	3,249,582		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,939	0	20,939		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	254,204	0	254,204		192.00
194.00	07950	MARKETING	0	0	0		194.00
194.01	07951	PHYSICIAN BILLING	21,669	0	21,669		194.01
194.02	07952	MOB	262,588	0	262,588		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,808,982	0	3,808,982		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	
			1.00	1.01	1.02	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	136,433					1.00
1.01	00101	MOB	0	34,271				1.01
1.02	00102	AMB DEPR	0	0	11,032			1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				136,433		2.00
2.01	00201	AMB EQUIP				0	11,032	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	200	0	0	200	0	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	20,111	196	0	20,111	0	5.01
5.02	00570	ADMITTING	0	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	15,688	0	0	15,688	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	916	0	0	916	0	8.00
9.00	00900	HOUSEKEEPING	1,962	0	0	1,962	0	9.00
10.00	01000	DIETARY	5,709	0	0	5,709	0	10.00
11.00	01100	CAFETERIA	2,852	0	0	2,852	0	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	1,143	0	3,185	0	16.00
17.00	01700	SOCIAL SERVICE	192	0	0	192	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,203	0	0	23,203	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	0	0	2,897	0	31.00
43.00	04300	NURSERY	600	0	0	600	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	0	0	17,722	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	0	0	9,285	0	54.00
60.00	06000	LABORATORY	4,880	0	0	4,880	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	0	1,062	0	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	0	3,593	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	0	0	1,824	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	0	1,226	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,613	0	0	0	90.00
90.01	09001	SENIOR CARE	0	1,170	0	0	0	90.01
90.02	09002	GENERAL SURGERY	0	2,260	0	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	3,158	0	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	3,158	0	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	4,831	0	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0	1,579	0	0	0	90.06
91.00	09100	EMERGENCY	6,559	1,613	0	6,559	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	11,032	0	11,032	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,502	20,721	11,032	128,502	11,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,616	0	0	6,616	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	0	500	0	194.01
194.02	07952	MOB	0	13,550	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,741,984	658,330	65,303	1,176,859	166,506	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.768055	19.209536	5.919416	8.625912	15.093002	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	
			1.00	1.01	1.02	2.00	2.01	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			4.00	5A.01	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	27,368,968					4.00
5.01	00590	ADMINISTRATIVE & GENERAL	1,567,314	-5,677,484	49,172,800			5.01
5.02	00570	ADMITTING	477,069	0	652,145	158,198,365		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	416,065	0	1,149,492	0	158,198,365	5.03
7.00	00700	OPERATION OF PLANT	259,501	0	2,073,456	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,912	0	282,842	0	0	8.00
9.00	00900	HOUSEKEEPING	523,965	0	919,079	0	0	9.00
10.00	01000	DIETARY	193,586	0	519,082	0	0	10.00
11.00	01100	CAFETERIA	246,383	0	442,367	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	665,564	0	899,493	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	218,166	0	844,950	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	608,410	0	1,015,194	0	0	16.00
17.00	01700	SOCIAL SERVICE	383,794	0	490,530	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,100,061	0	6,337,782	9,312,252	9,312,252	30.00
31.00	03100	INTENSIVE CARE UNIT	346,060	0	535,609	1,182,714	1,182,714	31.00
43.00	04300	NURSERY	140,592	0	158,618	1,364,816	1,364,816	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	977,744	0	1,960,334	13,558,713	13,558,713	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	10,961	2,684,412	2,684,412	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	997,885	0	2,164,992	35,950,012	35,950,012	54.00
60.00	06000	LABORATORY	795,365	0	2,442,991	25,164,800	25,164,800	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	529,525	2,748,572	2,748,572	65.00
66.00	06600	PHYSICAL THERAPY	302,712	0	455,416	2,406,276	2,406,276	66.00
67.00	06700	OCCUPATIONAL THERAPY	50,083	0	62,823	438,581	438,581	67.00
68.00	06800	SPEECH PATHOLOGY	3,924	0	4,907	108,419	108,419	68.00
69.00	06900	ELECTROCARDIOLOGY	435,749	0	658,249	8,690,399	8,690,399	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,879,158	4,997,241	4,997,241	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,303,624	4,108,490	4,108,490	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	352,052	0	2,903,185	9,569,440	9,569,440	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,172	0	93,314	198,392	198,392	90.00
90.01	09001	SENIOR CARE	98,506	0	279,351	308,800	308,800	90.01
90.02	09002	GENERAL SURGERY	869,597	0	344,101	109,147	109,147	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	571,076	0	516,076	658,544	658,544	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	514,222	0	373,191	817,017	817,017	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	1,208,786	0	468,806	677,115	677,115	90.05
90.06	09006	OBGYN - DR SAUER	495,052	0	189,445	147,793	147,793	90.06
91.00	09100	EMERGENCY	1,572,147	0	2,746,112	23,301,979	23,301,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,231,316	0	3,576,132	9,694,441	9,694,441	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,664,830	-5,677,484	39,283,332	158,198,365	158,198,365	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17,436	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,287,340	0	8,928,318	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	416,798	0	683,425	0	0	194.01
194.02	07952	MOB	0	0	260,289	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	984,055		5,677,484	727,442	1,282,212	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.035955		0.115460	0.004598	0.008105	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,279		434,264	5,833	10,216	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000156		0.008831	0.000037	0.000065	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT	100,434					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	916	207,668				8.00
9.00	00900	HOUSEKEEPING	1,962	0	97,556			9.00
10.00	01000	DIETARY	5,709	2,535	5,709	3,670		10.00
11.00	01100	CAFETERIA	2,852	0	2,852	0	30,681	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	480	0	897	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	656	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	3,185	0	1,484	16.00
17.00	01700	SOCIAL SERVICE	192	0	192	0	488	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,203	65,150	23,203	3,246	8,264	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	22,967	2,897	424	755	31.00
43.00	04300	NURSERY	600	0	600	0	301	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	14,333	17,722	0	2,360	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	26,293	9,285	0	2,270	54.00
60.00	06000	LABORATORY	4,880	0	4,880	0	1,564	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	1,062	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	3,593	0	455	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	75	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	6	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	3,094	1,824	0	746	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	4,356	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	1,226	0	332	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	469	0	0	36	90.00
90.01	09001	SENIOR CARE	0	56	0	0	149	90.01
90.02	09002	GENERAL SURGERY	0	226	0	0	567	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	0	0	0	937	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	200	0	0	739	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	68	0	0	1,000	90.05
90.06	09006	OBGYN - DR SAUER	0	446	0	0	304	90.06
91.00	09100	EMERGENCY	6,559	55,191	6,559	0	3,180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	10,050	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,503	201,078	89,625	3,670	27,565	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	815	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,616	6,590	6,616	0	1,989	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	500	0	1,127	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,312,857	336,593	1,070,378	777,233	590,413	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.028626	1.620823	10.971934	211.780109	19.243604	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	353,979	25,327	57,088	150,523	76,681	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.524494	0.121959	0.585182	41.014441	2.499299	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/28/2021 3:11 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			13.00	14.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	15,791					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,032,416				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,284	158,198,365			16.00
17.00	01700	SOCIAL SERVICE	0	1,041	0	4,365		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,264	271,491	9,312,252	3,246		30.00
31.00	03100	INTENSIVE CARE UNIT	755	29,888	1,182,714	424		31.00
43.00	04300	NURSERY	301	145	1,364,816	695		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,360	409,615	13,558,713	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	26,289	2,684,412	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	178,628	35,950,012	0		54.00
60.00	06000	LABORATORY	0	1,039,521	25,164,800	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	30,328	2,748,572	0		65.00
66.00	06600	PHYSICAL THERAPY	0	3,758	2,406,276	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	193	438,581	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	108,419	0		68.00
69.00	06900	ELECTROCARDIOLOGY	746	40,844	8,690,399	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,839,712	4,997,241	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,303,624	4,108,490	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,329	9,569,440	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	36	12,956	198,392	0		90.00
90.01	09001	SENIOR CARE	149	667	308,800	0		90.01
90.02	09002	GENERAL SURGERY	0	5,669	109,147	0		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	44,367	658,544	0		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	43,165	817,017	0		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	393,440	677,115	0		90.05
90.06	09006	OBGYN - DR SAUER	0	28,515	147,793	0		90.06
91.00	09100	EMERGENCY	3,180	116,310	23,301,979	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	177,637	9,694,441	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,791	6,032,416	158,198,365	4,365		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	MARKETING	0	0	0	0		194.00
194.01	07951	PHYSICIAN BILLING	0	0	0	0		194.01
194.02	07952	MOB	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,036,931	955,132	1,272,470	563,251		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	65.665949	0.158333	0.008044	129.038030		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	22,531	9,136	115,986	10,510		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.426825	0.001514	0.000733	2.407789		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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,008,229		10,008,229	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	971,059		971,059	0	0	31.00
43.00	04300	NURSERY	340,909		340,909	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,359,008		3,359,008	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	72,082		72,082	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,591,073		3,591,073	0	0	54.00
60.00	06000	LABORATORY	3,607,764		3,607,764	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	688,599	0	688,599	0	0	65.00
66.00	06600	PHYSICAL THERAPY	689,436	0	689,436	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	80,651	0	80,651	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,839	0	7,839	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,051,392		1,051,392	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,639,197		2,639,197	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,745,786		1,745,786	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,487,267		3,487,267	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	114,072		114,072	0	0	90.00
90.01	09001	SENIOR CARE	330,860		330,860	0	0	90.01
90.02	09002	GENERAL SURGERY	398,271		398,271	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	614,380		614,380	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	454,610		454,610	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	618,631		618,631	0	0	90.05
90.06	09006	OBGYN - DR SAUER	225,473		225,473	0	0	90.06
91.00	09100	EMERGENCY	4,147,518		4,147,518	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,182,462		2,182,462		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,234,577		4,234,577	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	45,661,145	0	45,661,145	0	0	200.00
201.00		Less Observation Beds	2,182,462		2,182,462		0	201.00
202.00		Total (see instructions)	43,478,683	0	43,478,683	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/28/2021 3:11 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,462,491		7,462,491			30.00
31.00	03100	INTENSIVE CARE UNIT	1,182,714		1,182,714			31.00
43.00	04300	NURSERY	1,364,816		1,364,816			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,938,504	10,620,209	13,558,713	0.247738	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	923,233	1,761,179	2,684,412	0.026852	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,375,121	34,574,891	35,950,012	0.099891	0.000000	54.00
60.00	06000	LABORATORY	3,414,610	21,750,190	25,164,800	0.143365	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,910,608	837,964	2,748,572	0.250530	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	673,827	1,732,449	2,406,276	0.286516	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	280,247	158,334	438,581	0.183891	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	60,106	48,313	108,419	0.072303	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	585,534	8,104,865	8,690,399	0.120983	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,460,873	2,536,368	4,997,241	0.528131	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,697,172	2,411,318	4,108,490	0.424922	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,328,756	7,240,684	9,569,440	0.364417	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	198,392	198,392	0.574983	0.000000	90.00
90.01	09001	SENIOR CARE	0	308,800	308,800	1.071438	0.000000	90.01
90.02	09002	GENERAL SURGERY	0	109,147	109,147	3.648941	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	658,544	658,544	0.932937	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	817,017	817,017	0.556427	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	677,115	677,115	0.913628	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	0	147,793	147,793	1.525600	0.000000	90.06
91.00	09100	EMERGENCY	403,494	22,898,485	23,301,979	0.177990	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,849,761	1,849,761	1.179862	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	9,694,441	9,694,441	0.436805	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,062,106	129,136,259	158,198,365			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	29,062,106	129,136,259	158,198,365			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/28/2021 3:11 pm

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		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	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	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
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
90.02	09002	GENERAL SURGERY	0.000000		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.000000		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.000000		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.000000		90.05
90.06	09006	OBGYN - DR SAUER	0.000000		90.06
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/28/2021 3:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,008,229		10,008,229	0	10,008,229	30.00
31.00	03100	INTENSIVE CARE UNIT	971,059		971,059	0	971,059	31.00
43.00	04300	NURSERY	340,909		340,909	0	340,909	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,359,008		3,359,008	0	3,359,008	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	72,082		72,082	0	72,082	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,591,073		3,591,073	0	3,591,073	54.00
60.00	06000	LABORATORY	3,607,764		3,607,764	0	3,607,764	60.00
65.00	06500	RESPIRATORY THERAPY	688,599	0	688,599	0	688,599	65.00
66.00	06600	PHYSICAL THERAPY	689,436	0	689,436	0	689,436	66.00
67.00	06700	OCCUPATIONAL THERAPY	80,651	0	80,651	0	80,651	67.00
68.00	06800	SPEECH PATHOLOGY	7,839	0	7,839	0	7,839	68.00
69.00	06900	ELECTROCARDIOLOGY	1,051,392		1,051,392	0	1,051,392	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,639,197		2,639,197	0	2,639,197	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,745,786		1,745,786	0	1,745,786	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,487,267		3,487,267	0	3,487,267	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	114,072		114,072	0	114,072	90.00
90.01	09001	SENIOR CARE	330,860		330,860	0	330,860	90.01
90.02	09002	GENERAL SURGERY	398,271		398,271	0	398,271	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	614,380		614,380	0	614,380	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	454,610		454,610	0	454,610	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	618,631		618,631	0	618,631	90.05
90.06	09006	OBGYN - DR SAUER	225,473		225,473	0	225,473	90.06
91.00	09100	EMERGENCY	4,147,518		4,147,518	0	4,147,518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,182,462		2,182,462		2,182,462	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,234,577		4,234,577	0	4,234,577	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	45,661,145	0	45,661,145	0	45,661,145	200.00
201.00		Less Observation Beds	2,182,462		2,182,462		2,182,462	201.00
202.00		Total (see instructions)	43,478,683	0	43,478,683	0	43,478,683	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/28/2021 3:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,462,491		7,462,491			30.00
31.00	03100	INTENSIVE CARE UNIT	1,182,714		1,182,714			31.00
43.00	04300	NURSERY	1,364,816		1,364,816			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,938,504	10,620,209	13,558,713	0.247738	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	923,233	1,761,179	2,684,412	0.026852	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,375,121	34,574,891	35,950,012	0.099891	0.000000	54.00
60.00	06000	LABORATORY	3,414,610	21,750,190	25,164,800	0.143365	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,910,608	837,964	2,748,572	0.250530	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	673,827	1,732,449	2,406,276	0.286516	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	280,247	158,334	438,581	0.183891	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	60,106	48,313	108,419	0.072303	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	585,534	8,104,865	8,690,399	0.120983	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,460,873	2,536,368	4,997,241	0.528131	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,697,172	2,411,318	4,108,490	0.424922	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,328,756	7,240,684	9,569,440	0.364417	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	198,392	198,392	0.574983	0.000000	90.00
90.01	09001	SENIOR CARE	0	308,800	308,800	1.071438	0.000000	90.01
90.02	09002	GENERAL SURGERY	0	109,147	109,147	3.648941	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	658,544	658,544	0.932937	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	817,017	817,017	0.556427	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	677,115	677,115	0.913628	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	0	147,793	147,793	1.525600	0.000000	90.06
91.00	09100	EMERGENCY	403,494	22,898,485	23,301,979	0.177990	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,849,761	1,849,761	1.179862	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	9,694,441	9,694,441	0.436805	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,062,106	129,136,259	158,198,365			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	29,062,106	129,136,259	158,198,365			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/28/2021 3:11 pm

Title XIX | Hospital | 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	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	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
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
90.02	09002	GENERAL SURGERY	0.000000		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.000000		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.000000		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.000000		90.05
90.06	09006	OBGYN - DR SAUER	0.000000		90.06
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	492,395	13,558,713	0.036316	686,872	24,944	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,378	2,684,412	0.000886	129,255	115	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	295,185	35,950,012	0.008211	493,041	4,048	54.00
60.00	06000	LABORATORY	172,652	25,164,800	0.006861	1,185,345	8,133	60.00
65.00	06500	RESPIRATORY THERAPY	34,103	2,748,572	0.012408	999,600	12,403	65.00
66.00	06600	PHYSICAL THERAPY	98,857	2,406,276	0.041083	346,516	14,236	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,116	438,581	0.002545	138,825	353	67.00
68.00	06800	SPEECH PATHOLOGY	149	108,419	0.001374	4,640	6	68.00
69.00	06900	ELECTROCARDIOLOGY	63,024	8,690,399	0.007252	274,378	1,990	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	134,649	4,997,241	0.026945	927,833	25,000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,917	4,108,490	0.004118	748,241	3,081	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,802	9,569,440	0.006876	927,285	6,376	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	32,195	198,392	0.162280	0	0	90.00
90.01	09001	SENIOR CARE	25,807	308,800	0.083572	0	0	90.01
90.02	09002	GENERAL SURGERY	48,134	109,147	0.441002	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	68,269	658,544	0.103667	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	66,658	817,017	0.081587	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	100,798	677,115	0.148864	0	0	90.05
90.06	09006	OBGYN - DR SAUER	33,062	147,793	0.223705	0	0	90.06
91.00	09100	EMERGENCY	261,608	23,301,979	0.011227	16,789	188	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	182,718	1,849,761	0.098779	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,196,476	138,493,903		6,878,620	100,873	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
90.02	09002	GENERAL SURGERY	0	0	0	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	0	0	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	0	0	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	13,558,713	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,684,412	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	35,950,012	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	25,164,800	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,748,572	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,406,276	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	438,581	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	108,419	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,690,399	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,997,241	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,108,490	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,569,440	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	198,392	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	308,800	0.000000	90.01
90.02	09002	GENERAL SURGERY	0	0	0	109,147	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	0	0	658,544	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	0	0	817,017	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	677,115	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	0	0	0	147,793	0.000000	90.06
91.00	09100	EMERGENCY	0	0	0	23,301,979	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,849,761	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	138,493,903		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	686,872	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	129,255	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	493,041	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,185,345	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	999,600	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	346,516	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	138,825	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	4,640	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	274,378	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	927,833	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	748,241	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	927,285	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.000000	0	0	0	0	90.01
90.02	09002	GENERAL SURGERY	0.000000	0	0	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.000000	0	0	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.000000	0	0	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.000000	0	0	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0.000000	0	0	0	0	90.06
91.00	09100	EMERGENCY	0.000000	16,789	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		6,878,620	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.247738	0	2,434,130	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.026852	0	394,381	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099891	0	10,303,405	0	0	54.00
60.00	06000	LABORATORY	0.143365	0	5,434,050	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.250530	0	379,656	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.286516	0	441,192	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.183891	0	34,508	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.072303	0	7,675	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.120983	0	2,766,525	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.528131	0	812,340	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.424922	0	445,064	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.364417	0	4,332,833	38,457	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.574983	0	39,301	0	0	90.00
90.01	09001	SENIOR CARE	1.071438	0	225,454	0	0	90.01
90.02	09002	GENERAL SURGERY	3.648941	0	3,464	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.932937	0	12,327	830	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.556427	0	13,067	809	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.913628	0	35,461	0	0	90.05
90.06	09006	OBGYN - DR SAUER	1.525600	0	3,400	1,081	0	90.06
91.00	09100	EMERGENCY	0.177990	0	5,781,047	11,593	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.179862	0	721,343	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.436805		0			95.00
200.00		Subtotal (see instructions)		0	34,620,623	52,770	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	34,620,623	52,770	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	603,026	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	10,590	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,029,217	0		54.00
60.00	06000	LABORATORY	779,053	0		60.00
65.00	06500	RESPIRATORY THERAPY	95,115	0		65.00
66.00	06600	PHYSICAL THERAPY	126,409	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,346	0		67.00
68.00	06800	SPEECH PATHOLOGY	555	0		68.00
69.00	06900	ELECTROCARDIOLOGY	334,702	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	429,022	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	189,117	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,578,958	14,014		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	22,597	0		90.00
90.01	09001	SENIOR CARE	241,560	0		90.01
90.02	09002	GENERAL SURGERY	12,640	0		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	11,500	774		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	7,271	450		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	32,398	0		90.05
90.06	09006	OBGYN - DR SAUER	5,187	1,649		90.06
91.00	09100	EMERGENCY	1,028,969	2,063		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	851,085	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	7,395,317	18,950		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,395,317	18,950		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/28/2021 3:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.247738	0	179,525	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.026852	0	138,311	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099891	0	853,095	0	0	54.00
60.00	06000	LABORATORY	0.143365	0	538,428	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.250530	0	11,158	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.286516	0	5,984	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.183891	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.072303	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.120983	0	106,372	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.528131	0	86,184	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.424922	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.364417	0	73,005	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.574983	0	3,302	0	0	90.00
90.01	09001	SENIOR CARE	1.071438	0	0	0	0	90.01
90.02	09002	GENERAL SURGERY	3.648941	0	10,136	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.932937	0	13,090	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.556427	0	4,459	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.913628	0	40,046	0	0	90.05
90.06	09006	OBGYN - DR SAUER	1.525600	0	98,806	0	0	90.06
91.00	09100	EMERGENCY	0.177990	0	828,246	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.179862	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.436805	0	285,239			95.00
200.00		Subtotal (see instructions)		0	3,275,386	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	3,275,386	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/28/2021 3:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	44,475	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,714	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,217	0	54.00
60.00	06000	LABORATORY	77,192	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,795	0	65.00
66.00	06600	PHYSICAL THERAPY	1,715	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,869	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,516	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,604	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1,899	0	90.00
90.01	09001	SENIOR CARE	0	0	90.01
90.02	09002	GENERAL SURGERY	36,986	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	12,212	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	2,481	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	36,587	0	90.05
90.06	09006	OBGYN - DR SAUER	150,738	0	90.06
91.00	09100	EMERGENCY	147,420	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	124,594		95.00
200.00		Subtotal (see instructions)	813,014	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	813,014	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,439	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,214	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,246	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	225	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,325	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	225	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	118.90	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	118.90	20.00
21.00	Total general inpatient routine service cost (see instructions)	10,008,229	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	507,287	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,500,942	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,500,942	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,254.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,987,358	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,987,358	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	971,059	424	2,290.23	193	442,014	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,950,460	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,379,832	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	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 excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	507,287	64.00
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 CAH (see instructions)	507,287	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	968	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,254.61	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,182,462	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (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	837,901	10,008,229	0.083721	2,182,462	182,718	90.00
91.00	Nursing School cost	0	10,008,229	0.000000	2,182,462	0	91.00
92.00	Allied health cost	0	10,008,229	0.000000	2,182,462	0	92.00
93.00	All other Medical Education	0	10,008,229	0.000000	2,182,462	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,030,979		30.00
31.00	03100	INTENSIVE CARE UNIT		553,112		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.247738	686,872	170,164	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.026852	129,255	3,471	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099891	493,041	49,250	54.00
60.00	06000	LABORATORY	0.143365	1,185,345	169,937	60.00
65.00	06500	RESPIRATORY THERAPY	0.250530	999,600	250,430	65.00
66.00	06600	PHYSICAL THERAPY	0.286516	346,516	99,282	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.183891	138,825	25,529	67.00
68.00	06800	SPEECH PATHOLOGY	0.072303	4,640	335	68.00
69.00	06900	ELECTROCARDIOLOGY	0.120983	274,378	33,195	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.528131	927,833	490,017	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.424922	748,241	317,944	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.364417	927,285	337,918	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.574983	0	0	90.00
90.01	09001	SENIOR CARE	1.071438	0	0	90.01
90.02	09002	GENERAL SURGERY	3.648941	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.932937	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.556427	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.913628	0	0	90.05
90.06	09006	OBGYN - DR SAUER	1.525600	0	0	90.06
91.00	09100	EMERGENCY	0.177990	16,789	2,988	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.179862	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,878,620	1,950,460	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		6,878,620		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.247738	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.026852	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099891	8,946	894	54.00
60.00	06000	LABORATORY	0.143365	26,705	3,829	60.00
65.00	06500	RESPIRATORY THERAPY	0.250530	69,892	17,510	65.00
66.00	06600	PHYSICAL THERAPY	0.286516	108,828	31,181	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.183891	55,987	10,296	67.00
68.00	06800	SPEECH PATHOLOGY	0.072303	1,135	82	68.00
69.00	06900	ELECTROCARDIOLOGY	0.120983	404	49	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.528131	17,199	9,083	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.424922	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.364417	33,216	12,104	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.574983	0	0	90.00
90.01	09001	SENIOR CARE	1.071438	0	0	90.01
90.02	09002	GENERAL SURGERY	3.648941	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.932937	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.556427	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.913628	0	0	90.05
90.06	09006	OBGYN - DR SAUER	1.525600	0	0	90.06
91.00	09100	EMERGENCY	0.177990	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.179862	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		322,312	85,028	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		322,312		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 6/28/2021 3:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		391,279		30.00
31.00	03100	INTENSIVE CARE UNIT		4,335		31.00
43.00	04300	NURSERY		131,636		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.247738	75,563	18,720	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.026852	39,427	1,059	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099891	10,085	1,007	54.00
60.00	06000	LABORATORY	0.143365	99,583	14,277	60.00
65.00	06500	RESPIRATORY THERAPY	0.250530	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.286516	2,866	821	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.183891	1,336	246	67.00
68.00	06800	SPEECH PATHOLOGY	0.072303	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.120983	10,641	1,287	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.528131	217,140	114,678	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.424922	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.364417	29,125	10,614	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.574983	0	0	90.00
90.01	09001	SENIOR CARE	1.071438	0	0	90.01
90.02	09002	GENERAL SURGERY	3.648941	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.932937	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.556427	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.913628	0	0	90.05
90.06	09006	OBGYN - DR SAUER	1.525600	0	0	90.06
91.00	09100	EMERGENCY	0.177990	794	141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.179862	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		486,560	162,850	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		486,560		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 6/28/2021 3:11 pm

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.247738	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.026852	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099891	0	0	54.00
60.00	06000	LABORATORY	0.143365	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.250530	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.286516	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.183891	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.072303	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.120983	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.528131	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.424922	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.364417	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.574983	0	0	90.00
90.01	09001	SENIOR CARE	1.071438	0	0	90.01
90.02	09002	GENERAL SURGERY	3.648941	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.932937	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.556427	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.913628	0	0	90.05
90.06	09006	OBGYN - DR SAUER	1.525600	0	0	90.06
91.00	09100	EMERGENCY	0.177990	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.179862	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 6/28/2021 3:11 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,414,267	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,414,267	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	7,488,410	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	107,770	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,800,232	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,580,408	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,580,408	30.00
31.00	Primary payer payments	254	31.00
32.00	Subtotal (line 30 minus line 31)	1,580,154	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	707,705	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	460,008	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	486,414	36.00
37.00	Subtotal (see instructions)	2,040,162	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,040,162	40.00
40.01	Sequestration adjustment (see instructions)	13,465	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	1,019,777	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	1,006,920	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,445,345		1,019,777	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	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 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,445,345		1,019,777	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1,552,359		1,006,920	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,997,704		2,026,697	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		404,269		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	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 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		404,269		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		186,349		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		590,618		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1331	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 6/28/2021 3:11 pm
	Title XVIII	Hospital	Cost

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 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 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 6/28/2021 3:11 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	512,360	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	85,878	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	225	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	598,238	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	598,238	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	598,238	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,696	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	594,542	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	594,542	0	19.00
19.01	Sequestration adjustment (see instructions)	3,924	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	404,269	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	186,349	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 6/28/2021 3:11 pm

Title XIX | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 6/28/2021 3:11 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,379,832	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	5,379,832	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,433,630	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,433,630	19.00
20.00	Deductibles (exclude professional component)	428,016	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,005,614	22.00
23.00	Coinsurance	1,056	23.00
24.00	Subtotal (line 22 minus line 23)	5,004,558	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	40,539	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	26,350	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	11,935	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,030,908	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	5,030,908	30.00
30.01	Sequestration adjustment (see instructions)	33,204	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,445,345	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	1,552,359	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

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

Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 6/28/2021 3:11 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,584,324	0	0	0	1.00
2.00	Temporary investments	636,619	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,344,260	0	0	0	4.00
5.00	Other receivable	11,394	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,344,625	0	0	0	7.00
8.00	Prepaid expenses	890,784	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,812,006	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,001,138	0	0	0	12.00
13.00	Land improvements	3,379,433	0	0	0	13.00
14.00	Accumulated depreciation	-2,582,533	0	0	0	14.00
15.00	Buildings	41,615,649	0	0	0	15.00
16.00	Accumulated depreciation	-26,825,295	0	0	0	16.00
17.00	Leasehold improvements	3,605,135	0	0	0	17.00
18.00	Accumulated depreciation	-762,296	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	28,709,252	0	0	0	23.00
24.00	Accumulated depreciation	-25,380,106	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	24,760,377	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	9,292,717	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	-752,669	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,540,048	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	49,112,431	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,151,815	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,816,293	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,298,524	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,266,632	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,093,753	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,093,753	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,360,385	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	31,752,046				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	31,752,046	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	49,112,431	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 6/28/2021 3:11 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		33,082,336		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,330,290				2.00
3.00	Total (sum of line 1 and line 2)		31,752,046		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		31,752,046		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		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 sheet (line 11 minus line 18)		31,752,046		0		19.00

		Endowment Fund	Plant Fund			
		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 sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/28/2021 3:11 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,259,246		7,259,246	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				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)	7,259,246		7,259,246	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,219,271		1,219,271	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 lines 11-15)	1,219,271		1,219,271	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,478,517		8,478,517	17.00
18.00	Ancillary services	20,012,894	135,681,795	155,694,689	18.00
19.00	Outpatient services	0	7,350	7,350	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	9,694,443	9,694,443	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	28,491,411	145,383,588	173,874,999	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		61,068,054		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		61,068,054		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1331	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Prepared: 6/28/2021 3:11 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	173,874,999	1.00
2.00	Less contractual allowances and discounts on patients' accounts	125,995,791	2.00
3.00	Net patient revenues (line 1 minus line 2)	47,879,208	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	61,068,054	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-13,188,846	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	13,738	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	518	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	123,850	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	13,821	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	219,900	22.00
23.00	Governmental appropriations	31,640	23.00
24.00	OTHER OPERATING INCOME	5,255,030	24.00
24.50	COVID-19 PHE Funding	6,200,059	24.50
25.00	Total other income (sum of lines 6-24)	11,858,556	25.00
26.00	Total (line 5 plus line 25)	-1,330,290	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,330,290	29.00