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: 15-0037	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/26/2022 3:57 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2022 Time: 3:57 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 BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HANCOCK REGIONAL HOSPITAL (15-0037) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Jon Miller		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jon Miller			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

	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	453,347	-102,550	0	-123,445	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		11,702		0	10.00
200.00	Total	0	453,347	-90,848	0	-123,445	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: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 3:57 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 801 NORTH STATE STREET	PO Box:			1.00
2.00	City: GREENFIELD	State: IN	Zip Code: 46140-	County: HANCOCK	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	HANCOCK REGIONAL HOSPITAL	150037	26900	1	07/01/1966	N	P	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									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	KNIGHTSTOWN RURAL HEALTH	153987	26900		09/22/1998	N	O	N	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)	01/01/2021	12/31/2021	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.	Y	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)	Y	Y		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
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.04
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.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 3:57 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	
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.	302	534	0	0	929	0	24.00
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.	1		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.	1		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)	Y	Y	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. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 3:57 pm

		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.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

		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)				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 3:57 pm

				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
		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 3:57 pm

		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)	N	N	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)	N	N	0	76.00

		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	Y	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?	N		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 3:57 pm

				V	XIX	
				1.00	2.00	
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	N	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
				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.	Y				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.	2				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	320,190	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	5.00		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 3:57 pm

		1.00	2.00	
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

	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0037	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 3:57 pm

		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: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2022 3:57 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	A		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 a nursing program? 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.	Y		7.00
8.00	Were nursing programs 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	02/16/2022	Y	02/16/2022	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: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 3:57 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		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		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.		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.		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.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0037	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 3:57 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.	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: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 3:57 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	71	25,915	0.00	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)		71	25,915	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,760	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		95	34,675	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		95				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: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 3:57 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)	1,063	302	4,512			1.00
2.00	HMO and other (see instructions)	428	1,463				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,063	302	4,512			7.00
8.00	INTENSIVE CARE UNIT	1,792	0	6,388			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)	2,855	302	10,900	0.00	764.47	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			148			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	252	1,771	3,841	0.00	3.40	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	767.87	27.00
28.00	Observation Bed Days		0	3,014			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			79			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	30			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: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 3:57 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	394	49	3,027	1.00
2.00	HMO and other (see instructions)			94	390		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	394	49	3,027	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					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 WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part II Date/Time Prepared: 5/26/2022 3:57 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	62,648,267	-251,626	62,396,641	1,479,232.00	42.18	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		2,371,331	0	2,371,331	14,681.00	161.52	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		110,971	0	110,971	4,979.00	22.29	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		12,975,668	-656,585	12,319,083	238,975.00	51.55	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		594,447	0	594,447	5,814.00	102.24	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		290,559	0	290,559	2,546.00	114.12	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,866,048	0	10,866,048			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		2,442,395	0	2,442,395			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		225,513	0	225,513			23.00
24.00	Wage-related costs (RHC/FQHC)		35,673	0	35,673			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part II | Date/Time Prepared: 5/26/2022 3:57 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	552,861	-8,816	544,045	13,740.00	39.60	26.00
27.00	Administrative & General	5.00	11,232,003	-282,091	10,949,912	243,448.00	44.98	27.00
28.00	Administrative & General under contract (see inst.)		395,593	0	395,593	2,804.00	141.08	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,288,734	-1,291	1,287,443	38,199.00	33.70	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,839,700	-10,336	1,829,364	92,641.00	19.75	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,551,557	-922,942	628,615	30,575.00	20.56	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	921,860	921,860	44,915.00	20.52	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,534,766	0	1,534,766	30,994.00	49.52	38.00
39.00	Central Services and Supply	14.00	227,789	0	227,789	7,763.00	29.34	39.00
40.00	Pharmacy	15.00	2,890,361	-9,457	2,880,904	67,717.00	42.54	40.00
41.00	Medical Records & Medical Records Library	16.00	634,288	0	634,288	23,957.00	26.48	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part III Date/Time Prepared: 5/26/2022 3:57 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		60,561,558	-251,626	60,309,932	1,462,376.00	41.24	1.00
2.00	Excluded area salaries (see instructions)		12,975,668	-656,585	12,319,083	238,975.00	51.55	2.00
3.00	Subtotal salaries (line 1 minus line 2)		47,585,890	404,959	47,990,849	1,223,401.00	39.23	3.00
4.00	Subtotal other wages & related costs (see inst.)		885,006	0	885,006	8,360.00	105.86	4.00
5.00	Subtotal wage-related costs (see inst.)		10,866,048	0	10,866,048	0.00	22.64	5.00
6.00	Total (sum of lines 3 thru 5)		59,336,944	404,959	59,741,903	1,231,761.00	48.50	6.00
7.00	Total overhead cost (see instructions)		22,147,652	-313,073	21,834,579	596,753.00	36.59	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part IV Date/Time Prepared: 5/26/2022 3:57 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	2,331,777	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6,483,048	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	512,066	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,255	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	4,163,424	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	6,181	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	56,172	22.00
23.00	Tuition Reimbursement	96,533	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,650,456	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part V Date/Time Prepared: 5/26/2022 3:57 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	586,152	13,650,456	1.00
2.00	Hospital	586,152	13,650,456	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-8 | Date/Time Prepared: 5/26/2022 3:57 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			224 WEST MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	KNIGHTSTOWN		IN	46148	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)		137632		07/01/2015	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

	1.00	2.00	
12.00 Have you received an approval for an exception to the productivity standard?	Y		12.00
13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		HANCOCK				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2021 To 12/31/2021	Worksheet S-8 Date/Time Prepared: 5/26/2022 3:57 pm
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	14:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/26/2022 3:57 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)	0.244123	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,196,783	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	47,678,864	6.00
7.00	Medicaid cost (line 1 times line 6)	11,639,507	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)	442,724	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)	442,724	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)	4,343,069	285,645	4,628,714	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,060,243	285,645	1,345,888	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)	1,060,243	285,645	1,345,888	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)	10,090,389	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	21,277	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	32,734	27.01
28.00	Non-Medicare bad debt expense (see instructions)	10,057,655	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,466,762	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,812,650	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,255,374	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 3:57 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		17,335,807	17,335,807	0	17,335,807	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	552,861	9,742,249	10,295,110	0	10,295,110	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,232,003	20,053,638	31,285,641	-1,019,885	30,265,756	5.00
7.00	00700	OPERATION OF PLANT	1,288,734	5,912,236	7,200,970	1,314	7,202,284	7.00
9.00	00900	HOUSEKEEPING	1,839,700	893,117	2,732,817	0	2,732,817	9.00
10.00	01000	DIETARY	1,551,557	1,263,174	2,814,731	-1,672,795	1,141,936	10.00
11.00	01100	CAFETERIA	0	0	0	1,672,795	1,672,795	11.00
13.00	01300	NURSING ADMINISTRATION	1,534,766	375,181	1,909,947	0	1,909,947	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	227,789	80,624	308,413	0	308,413	14.00
15.00	01500	PHARMACY	2,890,361	15,880,746	18,771,107	-14,955,267	3,815,840	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	634,288	310,654	944,942	4,270	949,212	16.00
23.00	02300	PARAMED ED PRGM	89,771	13,187	102,958	0	102,958	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,651,760	1,176,337	4,828,097	755,113	5,583,210	30.00
31.00	03100	INTENSIVE CARE UNIT	4,597,377	1,348,348	5,945,725	-191,683	5,754,042	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,832,358	4,112,463	7,944,821	-1,629,703	6,315,118	50.00
51.00	05100	RECOVERY ROOM	447,059	72,138	519,197	-22,415	496,782	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,786,221	2,236,308	6,022,529	-389,882	5,632,647	54.00
60.00	06000	LABORATORY	1,823,815	4,021,258	5,845,073	-657	5,844,416	60.00
65.00	06500	RESPIRATORY THERAPY	1,817,894	421,878	2,239,772	-60,471	2,179,301	65.00
66.00	06600	PHYSICAL THERAPY	1,231,507	204,681	1,436,188	-10,331	1,425,857	66.00
67.00	06700	OCCUPATIONAL THERAPY	352,325	32,923	385,248	-4,391	380,857	67.00
68.00	06800	SPEECH PATHOLOGY	161,389	18,173	179,562	-1,052	178,510	68.00
69.00	06900	ELECTROCARDIOLOGY	599,341	856,334	1,455,675	-621,951	833,724	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	360	360	3,374,555	3,374,915	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,590,585	1,590,585	7,171	1,597,756	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,793,987	15,793,987	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	71,087	15,710	86,797	-29	86,768	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	266,655	273,909	540,564	-37,045	503,519	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	387,336	607,693	995,029	-114,759	880,270	90.01
90.02	09002	DIABETES CLINIC	39,969	4,724	44,693	0	44,693	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	98,363	16,508	114,871	-182	114,689	90.04
90.05	09005	PRIME TIME	0	3,296	3,296	0	3,296	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	35,563	2,584	38,147	0	38,147	90.06
90.07	04951	ONCOLOGY	1,368,324	999,133	2,367,457	-37,541	2,329,916	90.07
90.08	04950	ANDERSON WOMENS CENTER	352,900	107,541	460,441	-59,675	400,766	90.08
91.00	09100	EMERGENCY	2,999,297	1,373,512	4,372,809	-265,290	4,107,519	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	944,262	170,366	1,114,628	-1,114,628	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,706,632	91,527,375	142,234,007	-600,427	141,633,580	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	249,391	249,391	-12,573	236,818	190.01
190.02	19002	PHYSICIAN BUILDING	0	501,973	501,973	0	501,973	190.02
190.03	19003	PRIVATE DUTY	291,270	778,121	1,069,391	-46	1,069,345	190.03
190.04	19004	MARKETING	0	0	0	1,016,479	1,016,479	190.04
190.05	19005	SPORTS PHYSICALS	243,641	21,763	265,404	-5	265,399	190.05
190.06	19006	FOUNDATION	235,446	911,956	1,147,402	0	1,147,402	190.06
190.07	19007	ASC	0	5,744	5,744	-4,599	1,145	190.07
190.08	19008	OTHER NONREIMBURSABLE	3,077,574	69,971	3,147,545	-111,025	3,036,520	190.08
190.09	19009	HANCOCK OB	4,182,020	2,109,613	6,291,633	-337,672	5,953,961	190.09
190.10	19010	HANCOCK WELLNESS	864,128	318,453	1,182,581	0	1,182,581	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	759,109	327,932	1,087,041	0	1,087,041	190.13
190.14	19014	3 WEST UNIT	227,510	204,622	432,132	-3,383	428,749	190.14
190.15	19015	NEUROLOGY PHYSICIAN	764,163	411,888	1,176,051	-82,264	1,093,787	190.15
190.16	19016	THORACI	80,310	26,058	106,368	0	106,368	190.16
190.17	19017	HANCOCK ENDO	585,953	210,193	796,146	0	796,146	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	-7	-7	7	0	190.18

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 3:57 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	
190.19	19019	HANCOCK RHEUM	69,456	23,303	92,759	0	92,759	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	60	60	0	60	194.00
194.01	07951	SUBURBAN HOSPICE	0	0	0	135,508	135,508	194.01
194.02	07952	HRH HANCOCK GI	521,055	32,311	553,366	0	553,366	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	40,000	0	40,000	0	40,000	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	62,648,267	97,730,720	160,378,987	0	160,378,987	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 3:57 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	-1,071,593	16,264,214		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,554,203	5,740,907		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,948,156	20,317,600		5.00
7.00	00700	OPERATION OF PLANT	-11,246	7,191,038		7.00
9.00	00900	HOUSEKEEPING	-151,651	2,581,166		9.00
10.00	01000	DIETARY	-830,498	311,438		10.00
11.00	01100	CAFETERIA	-625,006	1,047,789		11.00
13.00	01300	NURSING ADMINISTRATION	-6,271	1,903,676		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-8,893	299,520		14.00
15.00	01500	PHARMACY	-2,204,546	1,611,294		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-53,266	895,946		16.00
23.00	02300	PARAMED ED PRGM	-52,639	50,319		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-163,172	5,420,038		30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,754,042		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,339,904	3,975,214		50.00
51.00	05100	RECOVERY ROOM	0	496,782		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-266,918	5,365,729		54.00
60.00	06000	LABORATORY	-667,835	5,176,581		60.00
65.00	06500	RESPIRATORY THERAPY	-80,730	2,098,571		65.00
66.00	06600	PHYSICAL THERAPY	0	1,425,857		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	380,857		67.00
68.00	06800	SPEECH PATHOLOGY	0	178,510		68.00
69.00	06900	ELECTROCARDIOLOGY	0	833,724		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,374,915		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,597,756		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,793,987		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	86,768		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	503,519		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	-374,169	506,101		90.01
90.02	09002	DIABETES CLINIC	0	44,693		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	-45	114,644		90.04
90.05	09005	PRIME TIME	-3,615	-319		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	38,147		90.06
90.07	04951	ONCOLOGY	-662,774	1,667,142		90.07
90.08	04950	ANDERSON WOMENS CENTER	-60	400,706		90.08
91.00	09100	EMERGENCY	-469,329	3,638,190		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-24,546,519	117,087,061		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	236,818		190.01
190.02	19002	PHYSICIAN BUILDING	0	501,973		190.02
190.03	19003	PRIVATE DUTY	0	1,069,345		190.03
190.04	19004	MARKETING	0	1,016,479		190.04
190.05	19005	SPORTS PHYSICALS	0	265,399		190.05
190.06	19006	FOUNDATION	0	1,147,402		190.06
190.07	19007	ASC	0	1,145		190.07
190.08	19008	OTHER NONREIMBURSABLE	0	3,036,520		190.08
190.09	19009	HANCOCK OB	0	5,953,961		190.09
190.10	19010	HANCOCK WELLNESS	0	1,182,581		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	1,087,041		190.13
190.14	19014	3 WEST UNIT	0	428,749		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	1,093,787		190.15
190.16	19016	THORACI	0	106,368		190.16
190.17	19017	HANCOCK ENDO	0	796,146		190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0		190.18
190.19	19019	HANCOCK RHEUM	0	92,759		190.19
194.00	07950	OTHER NONREIMBURSABLE	0	60		194.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.01	07951	SUBURBAN HOSPICE	0	135,508		194.01
194.02	07952	HRH HANCOCK GI	0	553,366		194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	40,000		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-24,546,519	135,832,468		200.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 3:57 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	921,860	750,935		1.00
	0		921,860	750,935		
	B - PLANT RECLASS					
1.00	OPERATION OF PLANT	7.00	0	1,314		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,270		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	4,199		3.00
4.00	RESPIRATORY THERAPY	65.00	0	2,790		4.00
	0		0	12,573		
	C - MARKETING RECLASS					
1.00	MARKETING	190.04	175,128	841,351		1.00
	0		175,128	841,351		
	E - DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	15,793,987		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
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
	0		0	15,793,987		
	F - TERM ETO BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,816		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	106,963		2.00
3.00	OPERATION OF PLANT	7.00	0	1,291		3.00
4.00	HOUSEKEEPING	9.00	0	10,336		4.00
5.00	DIETARY	10.00	0	1,082		5.00
6.00	PHARMACY	15.00	0	9,457		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	27,183		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	15,933		8.00
9.00	OPERATING ROOM	50.00	0	5,617		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,723		10.00
11.00	LABORATORY	60.00	0	19,387		11.00
12.00	RESPIRATORY THERAPY	65.00	0	2,847		12.00
13.00	PHYSICAL THERAPY	66.00	0	49		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	7,935		14.00
15.00	WOUND CLINIC	90.01	0	8,716		15.00
16.00	ONCOLOGY	90.07	0	430		16.00
17.00	EMERGENCY	91.00	0	17,397		17.00
18.00	PRIVATE DUTY	190.03	0	2,351		18.00
19.00	OTHER NONREIMBURSABLE	190.08	0	857		19.00
20.00	HANCOCK OB	190.09	0	514		20.00
21.00	HANCOCK WELLNESS	190.10	0	367		21.00
22.00	MCCORD WELLNESS	190.13	0	308		22.00
23.00	SUBURBAN HOSPICE	194.01	0	67		23.00
	0		0	251,626		
	G - TRANSITIONS UNIT RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	827,249	149,254		1.00
2.00	SUBURBAN HOSPICE	194.01	117,013	21,112		2.00
	0		944,262	170,366		
	H - IMPLANTABLE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	7,171		1.00
	TOTALS		0	7,171		
	I - MED SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,374,639		1.00
2.00	HANCOCK FOOT & ANKLE	190.18	0	7		2.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 3:57 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
	TOTALS		0	3,374,646		
500.00	Grand Total: Increases		2,041,250	21,202,655		500.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 3:57 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	921,860	750,935	0		1.00
	0		921,860	750,935			
	B - PLANT RECLASS						
1.00	PROFESSIONAL BUILDING	190.01	0	12,573	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		0	12,573			
	C - MARKETING RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	175,128	841,351	0		1.00
	0		175,128	841,351			
	E - DRUG RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	52	0		1.00
2.00	PHARMACY	15.00	0	14,904,573	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	20,500	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	28,121	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	16	0		5.00
6.00	OPERATING ROOM	50.00	0	14,301	0		6.00
7.00	RECOVERY ROOM	51.00	0	1,186	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	255,341	0		8.00
9.00	LABORATORY	60.00	0	155	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	283	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	906	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	35,106	0		12.00
13.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	84	0		13.00
14.00	CARDIOPULMONARY	76.01	0	20	0		14.00
15.00	RURAL HEALTH CLINIC	88.00	0	37,045	0		15.00
16.00	WOUND CLINIC	90.01	0	15,367	0		16.00
17.00	ONCOLOGY	90.07	0	9,866	0		17.00
18.00	ANDERSON WOMENS CENTER	90.08	0	282	0		18.00
19.00	EMERGENCY	91.00	0	28,712	0		19.00
20.00	OTHER NONREIMBURSABLE	190.08	0	31,920	0		20.00
21.00	HANCOCK OB	190.09	0	327,503	0		21.00
22.00	NEUROLOGY PHYSICIAN	190.15	0	82,264	0		22.00
23.00	SUBURBAN HOSPICE	194.01	0	384	0		23.00
	0		0	15,793,987			
	F - TERM ETO BENEFIT RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	8,816	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	106,963	0	0		2.00
3.00	OPERATION OF PLANT	7.00	1,291	0	0		3.00
4.00	HOUSEKEEPING	9.00	10,336	0	0		4.00
5.00	DIETARY	10.00	1,082	0	0		5.00
6.00	PHARMACY	15.00	9,457	0	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	27,183	0	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	15,933	0	0		8.00
9.00	OPERATING ROOM	50.00	5,617	0	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	3,723	0	0		10.00
11.00	LABORATORY	60.00	19,387	0	0		11.00
12.00	RESPIRATORY THERAPY	65.00	2,847	0	0		12.00
13.00	PHYSICAL THERAPY	66.00	49	0	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	7,935	0	0		14.00
15.00	WOUND CLINIC	90.01	8,716	0	0		15.00
16.00	ONCOLOGY	90.07	430	0	0		16.00
17.00	EMERGENCY	91.00	17,397	0	0		17.00
18.00	PRIVATE DUTY	190.03	2,351	0	0		18.00
19.00	OTHER NONREIMBURSABLE	190.08	857	0	0		19.00
20.00	HANCOCK OB	190.09	514	0	0		20.00
21.00	HANCOCK WELLNESS	190.10	367	0	0		21.00
22.00	MCCORD WELLNESS	190.13	308	0	0		22.00
23.00	SUBURBAN HOSPICE	194.01	67	0	0		23.00
	0		251,626	0			
	G - TRANSITIONS UNIT RECLASS						
1.00	HOSPICE	116.00	944,262	170,366	0		1.00
2.00		0.00	0	0	0		2.00
	0		944,262	170,366			
	H - IMPLANTABLE RECLASS						
1.00	OTHER NONREIMBURSABLE	190.08	0	7,171	0		1.00
	TOTALS		0	7,171			
	I - MED SUPPLY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,354	0		1.00
2.00	PHARMACY	15.00	0	50,694	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	200,874	0		3.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 3:57 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
4.00	INTENSIVE CARE UNIT	31.00	0	163,562	0	4.00
5.00	OPERATING ROOM	50.00	0	1,615,402	0	5.00
6.00	RECOVERY ROOM	51.00	0	21,229	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	134,541	0	7.00
8.00	LABORATORY	60.00	0	502	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	62,978	0	9.00
10.00	PHYSICAL THERAPY	66.00	0	9,425	0	10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	4,391	0	11.00
12.00	SPEECH PATHOLOGY	68.00	0	1,052	0	12.00
13.00	ELECTROCARDIOLOGY	69.00	0	591,044	0	13.00
14.00	CARDIOPULMONARY	76.01	0	9	0	14.00
15.00	WOUND CLINIC	90.01	0	99,392	0	15.00
16.00	ANDIS CLINIC	90.04	0	182	0	16.00
17.00	ONCOLOGY	90.07	0	27,675	0	17.00
18.00	ANDERSON WOMENS CENTER	90.08	0	59,393	0	18.00
19.00	EMERGENCY	91.00	0	236,578	0	19.00
20.00	PRIVATE DUTY	190.03	0	46	0	20.00
21.00	SPORTS PHYSICALS	190.05	0	5	0	21.00
22.00	ASC	190.07	0	4,599	0	22.00
23.00	OTHER NONREIMBURSABLE	190.08	0	71,934	0	23.00
24.00	HANCOCK OB	190.09	0	10,169	0	24.00
25.00	3 WEST UNIT	190.14	0	3,383	0	25.00
26.00	SUBURBAN HOSPICE	194.01	0	2,233	0	26.00
	TOTALS		0	3,374,646		
500.00	Grand Total: Decreases		2,292,876	20,951,029		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2022 3:57 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	2,494,664	0	0	0	0	1.00
2.00	Land Improvements	22,003,738	4,214,080	0	4,214,080	0	2.00
3.00	Buildings and Fixtures	162,620,791	11,176,376	0	11,176,376	0	3.00
4.00	Building Improvements	235,570	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	93,664,018	2,272,974	0	2,272,974	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	281,018,781	17,663,430	0	17,663,430	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	281,018,781	17,663,430	0	17,663,430	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,494,664	0	1.00
2.00	Land Improvements	26,217,818	0	2.00
3.00	Buildings and Fixtures	173,797,167	0	3.00
4.00	Building Improvements	235,570	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	95,936,992	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	298,682,211	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	298,682,211	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II | Date/Time Prepared: 5/26/2022 3:57 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	15,537,119	0	0	1,350,602	448,086	1.00
3.00	Total (sum of lines 1-2)	15,537,119	0	0	1,350,602	448,086	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	17,335,807		1.00
3.00	Total (sum of lines 1-2)	0	17,335,807		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III | Date/Time Prepared: 5/26/2022 3:57 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	174,032,738	0	174,032,738	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	174,032,738	0	174,032,738	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	15,537,119	-1,067,790	1.00
3.00	Total (sum of lines 1-2)	0	0	0	15,537,119	-1,067,790	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	-3,803	1,350,602	448,086	0	16,264,214	1.00
3.00	Total (sum of lines 1-2)	-3,803	1,350,602	448,086	0	16,264,214	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 3:57 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
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of 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)		0		0.00	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	-5,255,240			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	-600,315	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		0		0.00	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
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 3:57 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	
33.00	PHARMACY - MISCELLANEOUS REVENUE	B	0		0.00	10	33.00
33.01	OTHER NON-DEPARTMENTAL - MISCELLANEO	B	0		0.00	0	33.01
33.02	INTERCOMPANY REVENUE	B	0		0.00	0	33.02
33.03	ADMINISTRATION MISCELLANEOUS EXPENSE	A	0		0.00	0	33.03
33.04	DONATIONS	A	0		0.00	0	33.04
33.05	INTEREST EXPENSE	A	0		0.00	0	33.05
33.06	LOBBYING % OF DUES	A	0		0.00	0	33.06
33.07	ADMINISTRATION LEGAL FEES	A	0		0.00	0	33.07
33.08	ADMINISTRATION - CONSULTING	A	0		0.00	0	33.08
33.09	HRH MMO RENTAL INCOME	B	-137,039	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.09
33.10	HRH HUMAN RESOURCES MISCELLANEOUS RE	B	-152,186	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	HRH OTHER REVENUE SALES TAX	B	-3,883	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	HRH OTHER REVENUE MISCELLANEOUS REVE	B	-17,732	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	HRH MED STAFF SERV QA APPLICATION FE	B	-19,600	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	HRH MED STAFF SERV MISCELLANEOUS REV	B	-5,880	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	HRH MEDICAL DUES MEDICAL STAFF DUES	B	-33,500	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	HRH PAT FIN. SERV. BUSINESS SERV-COP	B	-2,193	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	HRH INFO SERVICES MISCELLANEOUS REVE	B	-100,205	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	HRH ACCOUNTING MISCELLANEOUS REVENUE	B	-67,000	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	HRH ACCOUNTING MANAGEMENT FEES	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	HRH EXEC ADMIN MISCELLANEOUS REVENUE	B	-10,173	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	HRH PURCHASING MISCELLANEOUS REVENUE	B	-10	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	HRH COMMUNICATIONS MISCELLANEOUS REV	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	HRH COMMUNICATIONS PHONE LEASE REVEN	B	-108,951	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	HRH COMM EDUCATION EDUCATION SERVICE	B	-8,560	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	HRH HEALTHY 365 MISCELLANEOUS REVENU	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	HRH GAIN/LOSS GROSS VARIANCE INVENTO	B	4,701	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	HRH PLANT OFFSITE SERVICES	B	-9,710	OPERATION OF PLANT	7.00	0	33.27
33.28	HRH HOUSEKEEPING ENVIRONMENTAL SERVI	B	-151,651	HOUSEKEEPING	9.00	0	33.28
33.29	HRH NUTRITIONAL SER LTACH REVENUE	B	-88,654	DIETARY	10.00	0	33.29
33.30	HRH NUTRITIONAL SER MISCELLANEOUS RE	B	-171	DIETARY	10.00	0	33.30
33.31	HRH NUTRITIONAL SER REBATES/REFUNDS	B	-21	DIETARY	10.00	0	33.31
33.32	HRH CLINICAL EDUCAT AHA COURSE REVEN	B	-6,061	NURSING ADMINISTRATION	13.00	0	33.32
33.33	HRH CLINICAL EDUCAT EDUCATION SERVIC	B	-210	NURSING ADMINISTRATION	13.00	0	33.33
33.34	HRH OTHER REVENUE REBATES/REFUNDS	B	-6,774	CENTRAL SERVICES & SUPPLY	14.00	0	33.34
33.35	HRH OTHER REVENUE DISCOUNTS EARNED O	B	-2,119	CENTRAL SERVICES & SUPPLY	14.00	0	33.35
33.36	HRH PHARMACY MISCELLANEOUS REVENUE	B	0	PHARMACY	15.00	0	33.36
33.37	HRH PHARMACY REBATES/REFUNDS	B	-20,206	PHARMACY	15.00	0	33.37
33.38	HRH ASSOCIATE PHARM RETAIL PHARMACY-	B	-1,019,789	PHARMACY	15.00	0	33.38
33.39	HRH ASSOCIATE PHARM HOSPICE PHARMACY	B	-193,500	PHARMACY	15.00	0	33.39

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 3:57 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	
33.40	HRH ASSOCIATE PHARM PHARMACY MEDS TO	B	-6,593	PHARMACY	15.00	0	33.40
33.41	HRH ASSOCIATE PHARM MISCELLANEOUS RE	B	-28,127	PHARMACY	15.00	0	33.41
33.42	HRH HEALTH INFO SER MEDICAL RECORDS-	B	-919	MEDICAL RECORDS & LIBRARY	16.00	0	33.42
33.43	HRH HEALTH INFO SER MISCELLANEOUS RE	B	-52,347	MEDICAL RECORDS & LIBRARY	16.00	0	33.43
33.44	HRH X-RAY SCHOOL TUITION-X-RAY SCHOO	B	-52,639	PARAMED ED PRGM	23.00	0	33.44
33.45	HRH MED/SURG-2 EAST MISCELLANEOUS RE	B	0	ADULTS & PEDIATRICS	30.00	10	33.45
33.46	HRH ANDIS UNIT REBATES/REFUNDS	B	-789	ADULTS & PEDIATRICS	30.00	11	33.46
33.47	HRH SURGERY REBATES/REFUNDS	B	0	OPERATING ROOM	50.00	10	33.47
33.48	HRH LAB WATER TESTING	B	-69,670	LABORATORY	60.00	0	33.48
33.49	HRH LAB DIRECT TESTS	B	-28,210	LABORATORY	60.00	0	33.49
33.50	HRH LAB MISCELLANEOUS REVENUE	B	-473,705	LABORATORY	60.00	0	33.50
33.51	HRH WATER LAB WATER TESTING	B	0	LABORATORY	60.00	0	33.51
33.52	HRH SLEEP STUDY CLINIC MANAGMENT	B	-79,866	RESPIRATORY THERAPY	65.00	0	33.52
33.53	HRH MED ONCOLOGY MISCELLANEOUS REVEN	B	-1,680	ONCOLOGY	90.07	0	33.53
33.54	HRH E R REBATES/REFUNDS	B	-214	EMERGENCY	91.00	0	33.54
33.55	HRH HOSPICE MISCELLANEOUS REVENUE	B	-48,433	ADULTS & PEDIATRICS	30.00	0	33.55
33.56	MOW	A	-737,296	DIETARY	10.00	0	33.56
33.57	CAFETERIA GUEST MEALS	A	-24,691	CAFETERIA	11.00	0	33.57
33.58	PHYSICIAN RECRUITMENT FEES	A	-41,713	ADMINISTRATIVE & GENERAL	5.00	0	33.58
33.59	DONATIONS & SPONSORSHIPS	A	-316,326	ADMINISTRATIVE & GENERAL	5.00	0	33.59
33.60	ADVERTISING FEE	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.60
33.62	ADVERTISING FEE	A	-56,420	ADMINISTRATIVE & GENERAL	5.00	0	33.62
33.63	ADVERTISING FEE	A	-614,267	ADMINISTRATIVE & GENERAL	5.00	0	33.63
33.64	ADVERTISING FEE	A	-5,312	ADULTS & PEDIATRICS	30.00	0	33.64
33.65	ADVERTISING FEE	A	0	OPERATING ROOM	50.00	0	33.65
33.66	ADVERTISING FEE	A	-2,585	RADIOLOGY-DIAGNOSTIC	54.00	0	33.66
33.67	ADVERTISING FEE	A	-1,227	WOUND CLINIC	90.01	0	33.67
33.68	ADVERTISING FEE	A	0	SHELBYVILLE WOUND CLINIC	90.06	0	33.68
33.69	IHA LOBBYING EXPENSE	A	-3,580	ADMINISTRATIVE & GENERAL	5.00	0	33.69
33.70	AHA LOBBYING EXPENSE	A	-6,728	ADMINISTRATIVE & GENERAL	5.00	0	33.70
33.71	PHY OFFICE BLDG DEPR EXPENSE	A	-837,558	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.71
33.72	PHY OFFICE BLDG	A	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.72
33.73	PHY OFFICE BLDG	A	0	RURAL HEALTH CLINIC	88.00	0	33.73
33.74	INTEREST REVENUE	B	-3,803	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.74
33.75	RENTAL PROPERTIES EXPENSE	A	-93,193	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.75
33.76	RENTAL PROPERTIES EXPENSE	A	-223,451	ADMINISTRATIVE & GENERAL	5.00	0	33.76
33.77	RENTAL PROPERTIES EXPENSE	A	-1,036	OPERATION OF PLANT	7.00	0	33.77
33.78	TELEPHONE SERVICES	A	-49,969	ADMINISTRATIVE & GENERAL	5.00	0	33.78
33.79	HAF EXPENSE	A	-7,197,815	ADMINISTRATIVE & GENERAL	5.00	0	33.79
33.80	SELF INSURANCE CLAIM EXPENSE	A	-4,402,017	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.80
33.81	CLINICAL EDUCATION SERVICE REVENUE	B	0	NURSING ADMINISTRATION	13.00	0	33.81
33.82	3N MISCELLANEOUS REVENUE	B	-16,660	ADULTS & PEDIATRICS	30.00	0	33.82
33.83	CCU MISCELLANEOUS REVENUE	B	0	INTENSIVE CARE UNIT	31.00	0	33.83
33.84	SLEEP STUDY MISCELLANEOUS REVENUE	B	0	RESPIRATORY THERAPY	65.00	0	33.84
33.85	ULTRASOUND MISCELLANEOUS REVENUE	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.85
33.86	CT SCAN MISCELLANEOUS REVENUE	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.86
33.87	PIC AHN MISCELLANEOUS REVENUE	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.87
33.88	HOSPICE RENTAL INCOME	B	0	HOSPICE	116.00	0	33.88
33.89	HHA MISC REVENUE	B	-25	ADMINISTRATIVE & GENERAL	5.00	0	33.89
33.90	NUTRITIONAL SER CAF SALAD ROBOT	B	-4,356	DIETARY	10.00	0	33.90
33.91	PLANT MISCELLANEOUS REVENUE	B	-500	OPERATION OF PLANT	7.00	0	33.91
33.92	HOUSEKEEPING MISCELLANEOUS REVENUE	B	0	HOUSEKEEPING	9.00	0	33.92

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 3:57 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	
33.93	PAT FIN SERV EXPENSE REIMBURSEMENT	B	-46,792	ADMINISTRATIVE & GENERAL	5.00	0	33.93
33.94	PURCHASING REBATES AND REFUNDS	B	-54,633	ADMINISTRATIVE & GENERAL	5.00	0	33.94
33.95	HIFI MISCELLANEOUS REVENUE	B	-1,512	ADMINISTRATIVE & GENERAL	5.00	0	33.95
33.96	COMM EDUCATION MISCELLANEOUS REVENUE	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.96
33.97	ADVERTISING FEE	A	-45	ANDIS CLINIC	90.04	0	33.97
33.98	ADVERTISING FEE	A	-633	ADULTS & PEDIATRICS	30.00	0	33.98
33.99	ADVERTISING FEE	A	-60	ANDERSON WOMENS CENTER	90.08	0	33.99
34.00	ANDIS MISC REVENUE	B	-96	ADULTS & PEDIATRICS	30.00	0	34.00
34.01	IMMED CARE RAD RENTAL INCOME	B	-3,615	PRIME TIME	90.05	0	34.01
34.02	VACCINE CLINIC CLINIC MANAGEMENT	B	-936,331	PHARMACY	15.00	0	34.02
34.03	PATIENT FIN SERV MISC REVENUE	B	-2,450	ADMINISTRATIVE & GENERAL	5.00	0	34.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-24,546,519				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: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2022 3:57 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	5.00	ADMINISTRATIVE & GENERAL	959,489	959,489	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	91,249	91,249	0	211,500	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	2,206,310	2,206,310	0	246,400	0	4.00
5.00	50.00	OPERATING ROOM	133,594	133,594	0	211,500	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	264,333	264,333	0	211,500	0	6.00
7.00	60.00	LABORATORY	125,000	96,250	28,750	211,500	488	7.00
8.00	65.00	RESPIRATORY THERAPY	864	864	0	211,500	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	211,500	0	9.00
10.00	90.01	WOUND CLINIC	372,942	372,942	0	211,500	0	10.00
11.00	90.02	DIABETES CLINIC	0	0	0	211,500	0	11.00
12.00	90.04	ANDIS CLINIC	0	0	0	211,500	0	12.00
13.00	90.07	ONCOLOGY	661,094	661,094	0	211,500	0	13.00
14.00	91.00	EMERGENCY	469,115	469,115	0	211,500	0	14.00
200.00			5,283,990	5,255,240	28,750		488	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	49,621	2,481	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	90.01	WOUND CLINIC	0	0	0	0	0	10.00
11.00	90.02	DIABETES CLINIC	0	0	0	0	0	11.00
12.00	90.04	ANDIS CLINIC	0	0	0	0	0	12.00
13.00	90.07	ONCOLOGY	0	0	0	0	0	13.00
14.00	91.00	EMERGENCY	0	0	0	0	0	14.00
200.00			49,621	2,481	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	959,489		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	91,249		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0		3.00
4.00	50.00	OPERATING ROOM	0	0	0	2,206,310		4.00
5.00	50.00	OPERATING ROOM	0	0	0	133,594		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	264,333		6.00
7.00	60.00	LABORATORY	0	49,621	0	96,250		7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	864		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0		9.00
10.00	90.01	WOUND CLINIC	0	0	0	372,942		10.00
11.00	90.02	DIABETES CLINIC	0	0	0	0		11.00
12.00	90.04	ANDIS CLINIC	0	0	0	0		12.00
13.00	90.07	ONCOLOGY	0	0	0	661,094		13.00
14.00	91.00	EMERGENCY	0	0	0	469,115		14.00
200.00			0	49,621	0	5,255,240		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	16,264,214	16,264,214				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,740,907	83,629	5,824,536			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,317,600	1,407,745	1,031,128	22,756,473	22,756,473	5.00
7.00	00700	OPERATION OF PLANT	7,191,038	6,321,238	121,236	13,633,512	2,743,731	7.00
9.00	00900	HOUSEKEEPING	2,581,166	34,379	172,268	2,787,813	561,045	9.00
10.00	01000	DIETARY	311,438	318,849	59,195	689,482	138,758	10.00
11.00	01100	CAFETERIA	1,047,789	0	86,810	1,134,599	228,337	11.00
13.00	01300	NURSING ADMINISTRATION	1,903,676	0	144,526	2,048,202	412,199	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	299,520	127,712	21,450	448,682	90,297	14.00
15.00	01500	PHARMACY	1,611,294	248,899	271,289	2,131,482	428,959	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	895,946	61,107	59,730	1,016,783	204,627	16.00
23.00	02300	PARAMED ED PRGM	50,319	31,431	8,454	90,204	18,153	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,420,038	1,025,106	419,220	6,864,364	1,381,446	30.00
31.00	03100	INTENSIVE CARE UNIT	5,754,042	756,269	431,425	6,941,736	1,397,017	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,975,214	435,101	360,357	4,770,672	960,093	50.00
51.00	05100	RECOVERY ROOM	496,782	115,060	42,099	653,941	131,605	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,365,729	847,250	356,190	6,569,169	1,322,039	54.00
60.00	06000	LABORATORY	5,176,581	179,711	169,919	5,526,211	1,112,144	60.00
65.00	06500	RESPIRATORY THERAPY	2,098,571	187,395	170,919	2,456,885	494,446	65.00
66.00	06600	PHYSICAL THERAPY	1,425,857	160,203	115,964	1,702,024	342,531	66.00
67.00	06700	OCCUPATIONAL THERAPY	380,857	0	33,178	414,035	83,324	67.00
68.00	06800	SPEECH PATHOLOGY	178,510	0	15,198	193,708	38,984	68.00
69.00	06900	ELECTROCARDIOLOGY	833,724	153,115	55,692	1,042,531	209,808	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,374,915	0	0	3,374,915	679,198	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,597,756	0	0	1,597,756	321,547	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,793,987	0	0	15,793,987	3,178,502	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	86,768	41,301	6,694	134,763	27,121	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	503,519	0	25,110	528,629	106,386	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	506,101	110,986	35,654	652,741	131,363	90.01
90.02	09002	DIABETES CLINIC	44,693	0	3,764	48,457	9,752	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	114,644	15,831	9,263	139,738	28,122	90.04
90.05	09005	PRIME TIME	-319	0	0	-319	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	38,147	0	3,349	41,496	8,351	90.06
90.07	04951	ONCOLOGY	1,667,142	488,756	128,812	2,284,710	459,796	90.07
90.08	04950	ANDERSON WOMENS CENTER	400,706	138,575	33,232	572,513	115,218	90.08
91.00	09100	EMERGENCY	3,638,190	521,081	280,800	4,440,071	893,560	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	117,087,061	13,810,729	4,672,925	113,481,965	18,258,459	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	236,818	902,727	0	1,139,545	229,332	190.01
190.02	19002	PHYSICIAN BUILDING	501,973	0	0	501,973	101,022	190.02
190.03	19003	PRIVATE DUTY	1,069,345	14,805	27,207	1,111,357	223,659	190.03
190.04	19004	MARKETING	1,016,479	0	16,491	1,032,970	207,884	190.04
190.05	19005	SPORTS PHYSICALS	265,399	0	22,943	288,342	58,029	190.05
190.06	19006	FOUNDATION	1,147,402	63,955	22,171	1,233,528	248,246	190.06
190.07	19007	ASC	1,145	747,094	0	748,239	150,582	190.07
190.08	19008	OTHER NONREIMBURSABLE	3,036,520	0	289,728	3,326,248	669,404	190.08
190.09	19009	HANCOCK OB	5,953,961	215,977	393,764	6,563,702	1,320,938	190.09
190.10	19010	HANCOCK WELLNESS	1,182,581	6,293	81,339	1,270,213	255,629	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	1,087,041	0	71,455	1,158,496	233,146	190.13
190.14	19014	3 WEST UNIT	428,749	409,599	21,424	859,772	173,028	190.14
190.15	19015	NEUROLOGY PHYSICIAN	1,093,787	61,140	71,960	1,226,887	246,910	190.15

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
190.16	19016	THORACI	106,368	0	7,563	113,931	22,928	190.16
190.17	19017	HANCOCK ENDO	796,146	0	55,178	851,324	171,328	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	92,759	0	6,541	99,300	19,984	190.19
194.00	07950	OTHER NONREIMBURSABLE	60	0	0	60	12	194.00
194.01	07951	SUBURBAN HOSPICE	135,508	31,895	11,013	178,416	35,906	194.01
194.02	07952	HRH HANCOCK GI	553,366	0	49,067	602,433	121,239	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	40,000	0	3,767	43,767	8,808	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	135,832,468	16,264,214	5,824,536	135,832,468	22,756,473	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	16,377,243					7.00
9.00	00900	HOUSEKEEPING	74,761	3,423,619				9.00
10.00	01000	DIETARY	693,372	0	1,521,612			10.00
11.00	01100	CAFETERIA	0	59,614	0	1,422,550		11.00
13.00	01300	NURSING ADMINISTRATION	0	98,235	0	52,374	2,611,010	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	277,723	149,011	0	13,118	30,184	14.00
15.00	01500	PHARMACY	541,258	108,695	0	115,721	266,263	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	132,884	130,744	0	40,483	93,148	16.00
23.00	02300	PARAMED ED PRGM	68,350	150,606	0	3,295	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,229,205	999,211	849,656	155,523	357,844	30.00
31.00	03100	INTENSIVE CARE UNIT	1,644,588	206,001	661,968	183,951	423,248	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	946,175	399,976	0	88,205	202,953	50.00
51.00	05100	RECOVERY ROOM	250,210	147,280	0	14,228	32,738	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,842,437	146,415	0	159,634	367,304	54.00
60.00	06000	LABORATORY	390,800	139,718	0	104,620	240,722	60.00
65.00	06500	RESPIRATORY THERAPY	407,510	107,009	0	80,559	185,359	65.00
66.00	06600	PHYSICAL THERAPY	348,378	124,366	0	48,483	111,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	15,974	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	6,051	0	68.00
69.00	06900	ELECTROCARDIOLOGY	332,965	242,491	0	24,692	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	89,813	0	0	4,441	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	241,351	0	0	19,017	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	2,121	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	322,954	0	0	4,530	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	1,303	0	90.06
90.07	04951	ONCOLOGY	1,062,853	0	0	59,294	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	6,410	0	0	17,809	0	90.08
91.00	09100	EMERGENCY	1,133,148	214,247	0	108,385	249,385	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,037,145	3,423,619	1,511,624	1,323,811	2,560,702	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	21,865	50,308	190.03
190.04	19004	MARKETING	0	0	0	6,437	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	139,078	0	0	10,171	0	190.06
190.07	19007	ASC	1,624,638	0	0	0	0	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	469,666	0	0	43,212	0	190.09
190.10	19010	HANCOCK WELLNESS	13,684	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	890,717	0	0	8,875	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	132,956	0	0	3,295	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
190.17	19017	HANCOCK ENDO	0	0	0	5	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
194.01	07951	SUBURBAN HOSPICE	69,359	0	9,988	3,395	0	194.01
194.02	07952	HRH HANCOCK GI	0	0	0	1,484	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
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)	16,377,243	3,423,619	1,521,612	1,422,550	2,611,010	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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	1,009,015					14.00
15.00	01500	PHARMACY	0	3,592,378				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,618,669			16.00
23.00	02300	PARAMED ED PRGM	38,808	0	0	369,416		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	448,784	0	13,286,033	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	56,037	0	11,514,546	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	589,857	0	7,957,931	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	1,230,002	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	67,342	369,416	10,843,756	54.00
60.00	06000	LABORATORY	0	0	149,431	0	7,663,646	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	3,731,768	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,677,336	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	513,333	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	238,743	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1,852,487	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	970,207	0	76,682	0	5,101,002	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,919,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,592,378	0	0	22,564,867	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	0	256,138	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	635,015	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	1,044,472	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	60,330	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	495,344	90.04
90.05	09005	PRIME TIME	0	0	0	0	-319	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	51,150	90.06
90.07	04951	ONCOLOGY	0	0	0	0	3,866,653	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	711,950	90.08
91.00	09100	EMERGENCY	0	0	230,536	0	7,269,332	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,009,015	3,592,378	1,618,669	369,416	105,484,818	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	1,368,877	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	602,995	190.02
190.03	19003	PRIVATE DUTY	0	0	0	0	1,407,189	190.03
190.04	19004	MARKETING	0	0	0	0	1,247,291	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	346,371	190.05
190.06	19006	FOUNDATION	0	0	0	0	1,631,023	190.06
190.07	19007	ASC	0	0	0	0	2,523,459	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	3,995,652	190.08
190.09	19009	HANCOCK OB	0	0	0	0	8,397,518	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	1,539,526	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	1,391,642	190.13
190.14	19014	3 WEST UNIT	0	0	0	0	1,932,392	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	1,610,048	190.15
190.16	19016	THORACI	0	0	0	0	136,859	190.16
190.17	19017	HANCOCK ENDO	0	0	0	0	1,022,657	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	119,284	190.19

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	72	194.00
194.01	07951	SUBURBAN HOSPICE	0	0	0	0	297,064	194.01
194.02	07952	HRH HANCOCK GI	0	0	0	0	725,156	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	52,575	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,009,015	3,592,378	1,618,669	369,416	135,832,468	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
23.00	02300	PARAMED ED PRGM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	13,286,033		30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,514,546		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	7,957,931		50.00
51.00	05100	RECOVERY ROOM	0	1,230,002		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,843,756		54.00
60.00	06000	LABORATORY	0	7,663,646		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,731,768		65.00
66.00	06600	PHYSICAL THERAPY	0	2,677,336		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	513,333		67.00
68.00	06800	SPEECH PATHOLOGY	0	238,743		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,852,487		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,101,002		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,919,303		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,564,867		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	256,138		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	635,015		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	1,044,472		90.01
90.02	09002	DIABETES CLINIC	0	60,330		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	495,344		90.04
90.05	09005	PRIME TIME	0	-319		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	51,150		90.06
90.07	04951	ONCOLOGY	0	3,866,653		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	711,950		90.08
91.00	09100	EMERGENCY	0	7,269,332		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	105,484,818		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	1,368,877		190.01
190.02	19002	PHYSICIAN BUILDING	0	602,995		190.02
190.03	19003	PRIVATE DUTY	0	1,407,189		190.03
190.04	19004	MARKETING	0	1,247,291		190.04
190.05	19005	SPORTS PHYSICALS	0	346,371		190.05
190.06	19006	FOUNDATION	0	1,631,023		190.06
190.07	19007	ASC	0	2,523,459		190.07
190.08	19008	OTHER NONREIMBURSABLE	0	3,995,652		190.08
190.09	19009	HANCOCK OB	0	8,397,518		190.09
190.10	19010	HANCOCK WELLNESS	0	1,539,526		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	1,391,642		190.13
190.14	19014	3 WEST UNIT	0	1,932,392		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	1,610,048		190.15
190.16	19016	THORACI	0	136,859		190.16
190.17	19017	HANCOCK ENDO	0	1,022,657		190.17

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
190.18	19018	HANCOCK FOOT & ANKLE	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	119,284	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	72	194.00
194.01	07951	SUBURBAN HOSPICE	0	297,064	194.01
194.02	07952	HRH HANCOCK GI	0	725,156	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	52,575	194.03
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	135,832,468	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	83,629	83,629	83,629		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,407,745	1,407,745	14,808	1,422,553	5.00
7.00	00700	OPERATION OF PLANT	0	6,321,238	6,321,238	1,741	171,510	7.00
9.00	00900	HOUSEKEEPING	0	34,379	34,379	2,473	35,071	9.00
10.00	01000	DIETARY	0	318,849	318,849	850	8,674	10.00
11.00	01100	CAFETERIA	0	0	0	1,246	14,273	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,075	25,766	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	127,712	127,712	308	5,644	14.00
15.00	01500	PHARMACY	0	248,899	248,899	3,895	26,814	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,107	61,107	858	12,791	16.00
23.00	02300	PARAMED ED PRGM	0	31,431	31,431	121	1,135	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,025,106	1,025,106	6,019	86,354	30.00
31.00	03100	INTENSIVE CARE UNIT	0	756,269	756,269	6,194	87,327	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	435,101	435,101	5,174	60,015	50.00
51.00	05100	RECOVERY ROOM	0	115,060	115,060	604	8,227	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	847,250	847,250	5,114	82,640	54.00
60.00	06000	LABORATORY	0	179,711	179,711	2,440	69,520	60.00
65.00	06500	RESPIRATORY THERAPY	0	187,395	187,395	2,454	30,908	65.00
66.00	06600	PHYSICAL THERAPY	0	160,203	160,203	1,665	21,411	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	476	5,209	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	218	2,437	68.00
69.00	06900	ELECTROCARDIOLOGY	0	153,115	153,115	800	13,115	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	42,456	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	20,100	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	198,741	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	41,301	41,301	96	1,695	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	361	6,650	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	110,986	110,986	512	8,211	90.01
90.02	09002	DIABETES CLINIC	0	0	0	54	610	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	15,831	15,831	133	1,758	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	48	522	90.06
90.07	04951	ONCOLOGY	0	488,756	488,756	1,849	28,742	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	138,575	138,575	477	7,202	90.08
91.00	09100	EMERGENCY	0	521,081	521,081	4,032	55,856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	13,810,729	13,810,729	67,095	1,141,384	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	902,727	902,727	0	14,335	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	6,315	190.02
190.03	19003	PRIVATE DUTY	0	14,805	14,805	391	13,981	190.03
190.04	19004	MARKETING	0	0	0	237	12,995	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	329	3,627	190.05
190.06	19006	FOUNDATION	0	63,955	63,955	318	15,518	190.06
190.07	19007	ASC	0	747,094	747,094	0	9,413	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	4,160	41,844	190.08
190.09	19009	HANCOCK OB	0	215,977	215,977	5,653	82,571	190.09
190.10	19010	HANCOCK WELLNESS	0	6,293	6,293	1,168	15,979	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	1,026	14,574	190.13
190.14	19014	3 WEST UNIT	0	409,599	409,599	308	10,816	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	61,140	61,140	1,033	15,434	190.15
190.16	19016	THORACI	0	0	0	109	1,433	190.16

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
190.17	19017	HANCOCK ENDO	0	0	0	792	10,710	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	94	1,249	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	1	194.00
194.01	07951	SUBURBAN HOSPICE	0	31,895	31,895	158	2,244	194.01
194.02	07952	HRH HANCOCK GI	0	0	0	704	7,579	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	54	551	194.03
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	16,264,214	16,264,214	83,629	1,422,553	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	6,494,489					7.00
9.00	00900	HOUSEKEEPING	29,647	101,570				9.00
10.00	01000	DIETARY	274,961	0	603,334			10.00
11.00	01100	CAFETERIA	0	1,769	0	17,288		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,914	0	636	31,391	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	110,133	4,421	0	159	363	14.00
15.00	01500	PHARMACY	214,639	3,225	0	1,406	3,201	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	52,696	3,879	0	492	1,120	16.00
23.00	02300	PARAMED ED PRGM	27,105	4,468	0	40	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	884,004	29,643	336,897	1,890	4,302	30.00
31.00	03100	INTENSIVE CARE UNIT	652,171	6,112	262,477	2,237	5,089	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	375,211	11,866	0	1,072	2,440	50.00
51.00	05100	RECOVERY ROOM	99,222	4,369	0	173	394	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	730,629	4,344	0	1,940	4,416	54.00
60.00	06000	LABORATORY	154,974	4,145	0	1,271	2,894	60.00
65.00	06500	RESPIRATORY THERAPY	161,600	3,175	0	979	2,228	65.00
66.00	06600	PHYSICAL THERAPY	138,151	3,690	0	589	1,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	194	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	74	0	68.00
69.00	06900	ELECTROCARDIOLOGY	132,039	7,194	0	300	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	35,616	0	0	54	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	95,709	0	0	231	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	26	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	128,069	0	0	55	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	16	0	90.06
90.07	04951	ONCOLOGY	421,480	0	0	721	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	2,542	0	0	216	0	90.08
91.00	09100	EMERGENCY	449,356	6,356	0	1,317	2,998	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,169,954	101,570	599,374	16,088	30,786	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	266	605	190.03
190.04	19004	MARKETING	0	0	0	78	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	55,152	0	0	124	0	190.06
190.07	19007	ASC	644,259	0	0	0	0	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	186,249	0	0	525	0	190.09
190.10	19010	HANCOCK WELLNESS	5,427	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	353,219	0	0	108	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	52,724	0	0	40	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
190.17	19017	HANCOCK ENDO	0	0	0	0	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
194.01	07951	SUBURBAN HOSPICE	27,505	0	3,960	41	0	194.01
194.02	07952	HRH HANCOCK GI	0	0	0	18	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
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)	6,494,489	101,570	603,334	17,288	31,391	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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	248,740					14.00
15.00	01500	PHARMACY	0	502,079				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	132,943			16.00
23.00	02300	PARAMED ED PRGM	9,567	0	0	73,867		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	36,859		2,411,074	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	4,602		1,782,478	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	48,446		939,325	50.00
51.00	05100	RECOVERY ROOM	0	0	0		228,049	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,531		1,681,864	54.00
60.00	06000	LABORATORY	0	0	12,273		427,228	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		388,739	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		327,050	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		5,879	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		2,729	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		306,563	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	239,173	0	6,298		287,927	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		20,100	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	502,079	0		700,820	73.00
76.00	03020	CARDIAC	0	0	0		0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0		78,762	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0		7,011	88.00
90.00	09000	CLINIC	0	0	0		0	90.00
90.01	09001	WOUND CLINIC	0	0	0		215,649	90.01
90.02	09002	DIABETES CLINIC	0	0	0		690	90.02
90.03	09003	ASTHMA CLINIC	0	0	0		0	90.03
90.04	09004	ANDIS CLINIC	0	0	0		145,846	90.04
90.05	09005	PRIME TIME	0	0	0		0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		586	90.06
90.07	04951	ONCOLOGY	0	0	0		941,548	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0		149,012	90.08
91.00	09100	EMERGENCY	0	0	18,934		1,059,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0		0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	248,740	502,079	132,943	0	12,108,859	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		917,062	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		6,315	190.02
190.03	19003	PRIVATE DUTY	0	0	0		30,048	190.03
190.04	19004	MARKETING	0	0	0		13,310	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		3,956	190.05
190.06	19006	FOUNDATION	0	0	0		135,067	190.06
190.07	19007	ASC	0	0	0		1,400,766	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0		46,004	190.08
190.09	19009	HANCOCK OB	0	0	0		490,975	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		28,867	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		0	190.11
190.12	19012	O3PUREMED	0	0	0		0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0		15,600	190.13
190.14	19014	3 WEST UNIT	0	0	0		774,050	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		130,371	190.15
190.16	19016	THORACI	0	0	0		1,542	190.16
190.17	19017	HANCOCK ENDO	0	0	0		11,502	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0		0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0		1,343	190.19

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
194.00	07950	OTHER NONREIMBURSABLE	0	0	0		1	194.00
194.01	07951	SUBURBAN HOSPICE	0	0	0		65,803	194.01
194.02	07952	HRH HANCOCK GI	0	0	0		8,301	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		605	194.03
200.00		Cross Foot Adjustments				73,867	73,867	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	248,740	502,079	132,943	73,867	16,264,214	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
23.00	02300	PARAMED ED PRGM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,411,074		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,782,478		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	939,325		50.00
51.00	05100	RECOVERY ROOM	0	228,049		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,681,864		54.00
60.00	06000	LABORATORY	0	427,228		60.00
65.00	06500	RESPIRATORY THERAPY	0	388,739		65.00
66.00	06600	PHYSICAL THERAPY	0	327,050		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,879		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,729		68.00
69.00	06900	ELECTROCARDIOLOGY	0	306,563		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	287,927		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	20,100		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	700,820		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	78,762		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	7,011		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	215,649		90.01
90.02	09002	DIABETES CLINIC	0	690		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	145,846		90.04
90.05	09005	PRIME TIME	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	586		90.06
90.07	04951	ONCOLOGY	0	941,548		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	149,012		90.08
91.00	09100	EMERGENCY	0	1,059,930		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	12,108,859		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	917,062		190.01
190.02	19002	PHYSICIAN BUILDING	0	6,315		190.02
190.03	19003	PRIVATE DUTY	0	30,048		190.03
190.04	19004	MARKETING	0	13,310		190.04
190.05	19005	SPORTS PHYSICALS	0	3,956		190.05
190.06	19006	FOUNDATION	0	135,067		190.06
190.07	19007	ASC	0	1,400,766		190.07
190.08	19008	OTHER NONREIMBURSABLE	0	46,004		190.08
190.09	19009	HANCOCK OB	0	490,975		190.09
190.10	19010	HANCOCK WELLNESS	0	28,867		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	15,600		190.13
190.14	19014	3 WEST UNIT	0	774,050		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	130,371		190.15
190.16	19016	THORACI	0	1,542		190.16
190.17	19017	HANCOCK ENDO	0	11,502		190.17

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
190.18	19018	HANCOCK FOOT & ANKLE	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	1,343	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	1	194.00
194.01	07951	SUBURBAN HOSPICE	0	65,803	194.01
194.02	07952	HRH HANCOCK GI	0	8,301	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	605	194.03
200.00		Cross Foot Adjustments	0	73,867	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	16,264,214	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	491,065					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,525	61,852,596				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	42,504	10,949,912	-22,756,473	113,076,314		5.00
7.00	00700	OPERATION OF PLANT	190,857	1,287,443	0	13,633,512	227,387	7.00
9.00	00900	HOUSEKEEPING	1,038	1,829,364	0	2,787,813	1,038	9.00
10.00	01000	DIETARY	9,627	628,615	0	689,482	9,627	10.00
11.00	01100	CAFETERIA	0	921,860	0	1,134,599	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,534,766	0	2,048,202	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,856	227,789	0	448,682	3,856	14.00
15.00	01500	PHARMACY	7,515	2,880,904	0	2,131,482	7,515	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,845	634,288	0	1,016,783	1,845	16.00
23.00	02300	PARAMED ED PRGM	949	89,771	0	90,204	949	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,951	4,451,826	0	6,864,364	30,951	30.00
31.00	03100	INTENSIVE CARE UNIT	22,834	4,581,444	0	6,941,736	22,834	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,137	3,826,741	0	4,770,672	13,137	50.00
51.00	05100	RECOVERY ROOM	3,474	447,059	0	653,941	3,474	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,581	3,782,498	0	6,569,169	25,581	54.00
60.00	06000	LABORATORY	5,426	1,804,428	0	5,526,211	5,426	60.00
65.00	06500	RESPIRATORY THERAPY	5,658	1,815,047	0	2,456,885	5,658	65.00
66.00	06600	PHYSICAL THERAPY	4,837	1,231,458	0	1,702,024	4,837	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	352,325	0	414,035	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	161,389	0	193,708	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,623	591,406	0	1,042,531	4,623	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,374,915	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,597,756	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,793,987	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	1,247	71,087	0	134,763	1,247	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	266,655	0	528,629	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	3,351	378,620	0	652,741	3,351	90.01
90.02	09002	DIABETES CLINIC	0	39,969	0	48,457	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	478	98,363	0	139,738	4,484	90.04
90.05	09005	PRIME TIME	0	0	319	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	35,563	0	41,496	0	90.06
90.07	04951	ONCOLOGY	14,757	1,367,894	0	2,284,710	14,757	90.07
90.08	04950	ANDERSON WOMENS CENTER	4,184	352,900	0	572,513	89	90.08
91.00	09100	EMERGENCY	15,733	2,981,900	0	4,440,071	15,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	416,987	49,623,284	-22,756,154	90,725,811	181,012	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	27,256	0	0	1,139,545	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	501,973	0	190.02
190.03	19003	PRIVATE DUTY	447	288,919	0	1,111,357	0	190.03
190.04	19004	MARKETING	0	175,128	0	1,032,970	0	190.04
190.05	19005	SPORTS PHYSICALS	0	243,641	0	288,342	0	190.05
190.06	19006	FOUNDATION	1,931	235,446	0	1,233,528	1,931	190.06
190.07	19007	ASC	22,557	0	0	748,239	22,557	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	3,076,717	0	3,326,248	0	190.08
190.09	19009	HANCOCK OB	6,521	4,181,506	0	6,563,702	6,521	190.09
190.10	19010	HANCOCK WELLNESS	190	863,761	0	1,270,213	190	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	758,801	0	1,158,496	0	190.13
190.14	19014	3 WEST UNIT	12,367	227,510	0	859,772	12,367	190.14
190.15	19015	NEUROLOGY PHYSICIAN	1,846	764,163	0	1,226,887	1,846	190.15

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
190.16	19016	THORACI	0	80,310	0	113,931	0	190.16
190.17	19017	HANCOCK ENDO	0	585,953	0	851,324	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	69,456	0	99,300	0	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	60	0	194.00
194.01	07951	SUBURBAN HOSPICE	963	116,946	0	178,416	963	194.01
194.02	07952	HRH HANCOCK GI	0	521,055	0	602,433	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	40,000	0	43,767	0	194.03
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)	16,264,214	5,824,536		22,756,473	16,377,243	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.120288	0.094168		0.201249	72.023656	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		83,629		1,422,553	6,494,489	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001352		0.012580	28.561391	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: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING	375,765					9.00
10.00	01000	DIETARY	0	10,969				10.00
11.00	01100	CAFETERIA	6,543	0	841,833			11.00
13.00	01300	NURSING ADMINISTRATION	10,782	0	30,994	671,534		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,355	0	7,763	7,763	104	14.00
15.00	01500	PHARMACY	11,930	0	68,481	68,481	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,350	0	23,957	23,957	0	16.00
23.00	02300	PARAMED ED PRGM	16,530	0	1,950	0	4	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,670	6,125	92,035	92,035	0	30.00
31.00	03100	INTENSIVE CARE UNIT	22,610	4,772	108,857	108,857	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,900	0	52,198	52,198	0	50.00
51.00	05100	RECOVERY ROOM	16,165	0	8,420	8,420	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,070	0	94,468	94,468	0	54.00
60.00	06000	LABORATORY	15,335	0	61,912	61,912	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,745	0	47,673	47,673	0	65.00
66.00	06600	PHYSICAL THERAPY	13,650	0	28,691	28,691	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	9,453	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,581	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26,615	0	14,612	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	100	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
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	2,628	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	11,254	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	1,255	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	2,681	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	771	0	0	90.06
90.07	04951	ONCOLOGY	0	0	35,089	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	10,539	0	0	90.08
91.00	09100	EMERGENCY	23,515	0	64,140	64,140	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	375,765	10,897	783,402	658,595	104	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	12,939	12,939	0	190.03
190.04	19004	MARKETING	0	0	3,809	0	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	6,019	0	0	190.06
190.07	19007	ASC	0	0	0	0	0	190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	0	0	25,572	0	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	0	0	5,252	0	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	1,950	0	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
190.17	19017	HANCOCK ENDO	0	0	3	0	0	190.17

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	SUBURBAN HOSPICE	0	72	2,009	0	0	194.01
194.02	07952	HRH HANCOCK GI	0	0	878	0	0	194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
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)	3,423,619	1,521,612	1,422,550	2,611,010	1,009,015	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.111064	138.719300	1.689824	3.888128	9,702.067308	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	101,570	603,334	17,288	31,391	248,740	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.270302	55.003555	0.020536	0.046745	2,391.730769	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: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
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
15.00	01500	PHARMACY	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,293			16.00
23.00	02300	PARAMED ED PRGM	0	0	100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	913	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	114	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,200	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	137	100		54.00
60.00	06000	LABORATORY	0	304	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	156	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	0	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINIC	0	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0	0		90.04
90.05	09005	PRIME TIME	0	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		90.06
90.07	04951	ONCOLOGY	0	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0		90.08
91.00	09100	EMERGENCY	0	469	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	3,293	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		190.02
190.03	19003	PRIVATE DUTY	0	0	0		190.03
190.04	19004	MARKETING	0	0	0		190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		190.05
190.06	19006	FOUNDATION	0	0	0		190.06
190.07	19007	ASC	0	0	0		190.07
190.08	19008	OTHER NONREIMBURSABLE	0	0	0		190.08
190.09	19009	HANCOCK OB	0	0	0		190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		190.11
190.12	19012	O3PUREMED	0	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	0	0		190.13
190.14	19014	3 WEST UNIT	0	0	0		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		190.15
190.16	19016	THORACI	0	0	0		190.16
190.17	19017	HANCOCK ENDO	0	0	0		190.17

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:57 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0		190.18
190.19	19019	HANCOCK RHEUM	0	0	0		190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0		194.00
194.01	07951	SUBURBAN HOSPICE	0	0	0		194.01
194.02	07952	HRH HANCOCK GI	0	0	0		194.02
194.03	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.03
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)	3,592,378	1,618,669	369,416		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	35,923.780000	491.548436	3,694.160000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	502,079	132,943	73,867		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5,020.790000	40.371394	738.670000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:57 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,286,033		13,286,033	0	13,286,033	30.00
31.00	03100	INTENSIVE CARE UNIT	11,514,546		11,514,546	0	11,514,546	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,957,931		7,957,931	0	7,957,931	50.00
51.00	05100	RECOVERY ROOM	1,230,002		1,230,002	0	1,230,002	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,843,756		10,843,756	0	10,843,756	54.00
60.00	06000	LABORATORY	7,663,646		7,663,646	0	7,663,646	60.00
65.00	06500	RESPIRATORY THERAPY	3,731,768	0	3,731,768	0	3,731,768	65.00
66.00	06600	PHYSICAL THERAPY	2,677,336	0	2,677,336	0	2,677,336	66.00
67.00	06700	OCCUPATIONAL THERAPY	513,333	0	513,333	0	513,333	67.00
68.00	06800	SPEECH PATHOLOGY	238,743	0	238,743	0	238,743	68.00
69.00	06900	ELECTROCARDIOLOGY	1,852,487		1,852,487	0	1,852,487	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,101,002		5,101,002	0	5,101,002	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,919,303		1,919,303	0	1,919,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,564,867		22,564,867	0	22,564,867	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	256,138		256,138	0	256,138	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	635,015		635,015	0	635,015	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,044,472		1,044,472	0	1,044,472	90.01
90.02	09002	DIABETES CLINIC	60,330		60,330	0	60,330	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	495,344		495,344	0	495,344	90.04
90.05	09005	PRIME TIME	0		0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	51,150		51,150	0	51,150	90.06
90.07	04951	ONCOLOGY	3,866,653		3,866,653	0	3,866,653	90.07
90.08	04950	ANDERSON WOMENS CENTER	711,950		711,950	0	711,950	90.08
91.00	09100	EMERGENCY	7,269,332		7,269,332	0	7,269,332	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,320,765		5,320,765		5,320,765	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	110,805,902	0	110,805,902	0	110,805,902	200.00
201.00		Less Observation Beds	5,320,765		5,320,765		5,320,765	201.00
202.00		Total (see instructions)	105,485,137	0	105,485,137	0	105,485,137	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:57 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	8,957,828		8,957,828			30.00
31.00	03100	INTENSIVE CARE UNIT	15,037,855		15,037,855			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,447,084	22,560,008	30,007,092	0.265202	0.000000	50.00
51.00	05100	RECOVERY ROOM	825,790	1,725,919	2,551,709	0.482031	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,337,796	83,033,298	86,371,094	0.125548	0.000000	54.00
60.00	06000	LABORATORY	7,743,995	51,896,182	59,640,177	0.128498	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,787,846	7,975,742	12,763,588	0.292376	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	587,684	4,910,565	5,498,249	0.486943	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	464,165	906,501	1,370,666	0.374514	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	192,174	593,508	785,682	0.303867	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,176,546	13,241,182	16,417,728	0.112835	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	531,399	1,196,139	1,727,538	2.952758	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,410,647	4,888,586	7,299,233	0.262946	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,183,494	81,086,985	97,270,479	0.231981	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	411,407	411,407	0.622590	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	4,032	4,390,662	4,394,694	0.237667	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	18,223	18,223	3.310651	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	52,588	52,588	9.419335	0.000000	90.04
90.05	09005	PRIME TIME	0	3,974	3,974	0.000000	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0.000000	0.000000	90.06
90.07	04951	ONCOLOGY	9,173	4,597,072	4,606,245	0.839437	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	1,064	3,521,682	3,522,746	0.202101	0.000000	90.08
91.00	09100	EMERGENCY	5,037,012	53,579,963	58,616,975	0.124014	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	231,761	14,540,028	14,771,789	0.360198	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	76,967,345	355,130,214	432,097,559			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	76,967,345	355,130,214	432,097,559			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:57 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
40.00	04000	SUBPROVIDER - IPF		40.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.265202	50.00
51.00	05100	RECOVERY ROOM	0.482031	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125548	54.00
60.00	06000	LABORATORY	0.128498	60.00
65.00	06500	RESPIRATORY THERAPY	0.292376	65.00
66.00	06600	PHYSICAL THERAPY	0.486943	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.374514	67.00
68.00	06800	SPEECH PATHOLOGY	0.303867	68.00
69.00	06900	ELECTROCARDIOLOGY	0.112835	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.952758	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.262946	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.231981	73.00
76.00	03020	CARDIAC	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0.622590	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINIC	0.237667	90.01
90.02	09002	DIABETES CLINIC	3.310651	90.02
90.03	09003	ASTHMA CLINIC	0.000000	90.03
90.04	09004	ANDIS CLINIC	9.419335	90.04
90.05	09005	PRIME TIME	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	90.06
90.07	04951	ONCOLOGY	0.839437	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.202101	90.08
91.00	09100	EMERGENCY	0.124014	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.360198	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:57 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	13,286,033		13,286,033	0	13,286,033	30.00
31.00	03100	INTENSIVE CARE UNIT	11,514,546		11,514,546	0	11,514,546	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,957,931		7,957,931	0	7,957,931	50.00
51.00	05100	RECOVERY ROOM	1,230,002		1,230,002	0	1,230,002	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,843,756		10,843,756	0	10,843,756	54.00
60.00	06000	LABORATORY	7,663,646		7,663,646	0	7,663,646	60.00
65.00	06500	RESPIRATORY THERAPY	3,731,768	0	3,731,768	0	3,731,768	65.00
66.00	06600	PHYSICAL THERAPY	2,677,336	0	2,677,336	0	2,677,336	66.00
67.00	06700	OCCUPATIONAL THERAPY	513,333	0	513,333	0	513,333	67.00
68.00	06800	SPEECH PATHOLOGY	238,743	0	238,743	0	238,743	68.00
69.00	06900	ELECTROCARDIOLOGY	1,852,487		1,852,487	0	1,852,487	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,101,002		5,101,002	0	5,101,002	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,919,303		1,919,303	0	1,919,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,564,867		22,564,867	0	22,564,867	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	256,138		256,138	0	256,138	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	635,015		635,015	0	635,015	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,044,472		1,044,472	0	1,044,472	90.01
90.02	09002	DIABETES CLINIC	60,330		60,330	0	60,330	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	495,344		495,344	0	495,344	90.04
90.05	09005	PRIME TIME	0		0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	51,150		51,150	0	51,150	90.06
90.07	04951	ONCOLOGY	3,866,653		3,866,653	0	3,866,653	90.07
90.08	04950	ANDERSON WOMENS CENTER	711,950		711,950	0	711,950	90.08
91.00	09100	EMERGENCY	7,269,332		7,269,332	0	7,269,332	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,320,765		5,320,765		5,320,765	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	110,805,902	0	110,805,902	0	110,805,902	200.00
201.00		Less Observation Beds	5,320,765		5,320,765		5,320,765	201.00
202.00		Total (see instructions)	105,485,137	0	105,485,137	0	105,485,137	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:57 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	8,957,828		8,957,828			30.00
31.00	03100	INTENSIVE CARE UNIT	15,037,855		15,037,855			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,447,084	22,560,008	30,007,092	0.265202	0.000000	50.00
51.00	05100	RECOVERY ROOM	825,790	1,725,919	2,551,709	0.482031	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,337,796	83,033,298	86,371,094	0.125548	0.000000	54.00
60.00	06000	LABORATORY	7,743,995	51,896,182	59,640,177	0.128498	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,787,846	7,975,742	12,763,588	0.292376	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	587,684	4,910,565	5,498,249	0.486943	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	464,165	906,501	1,370,666	0.374514	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	192,174	593,508	785,682	0.303867	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,176,546	13,241,182	16,417,728	0.112835	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	531,399	1,196,139	1,727,538	2.952758	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,410,647	4,888,586	7,299,233	0.262946	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,183,494	81,086,985	97,270,479	0.231981	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	411,407	411,407	0.622590	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	4,032	4,390,662	4,394,694	0.237667	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	18,223	18,223	3.310651	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	52,588	52,588	9.419335	0.000000	90.04
90.05	09005	PRIME TIME	0	3,974	3,974	0.000000	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0.000000	0.000000	90.06
90.07	04951	ONCOLOGY	9,173	4,597,072	4,606,245	0.839437	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	1,064	3,521,682	3,522,746	0.202101	0.000000	90.08
91.00	09100	EMERGENCY	5,037,012	53,579,963	58,616,975	0.124014	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	231,761	14,540,028	14,771,789	0.360198	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	76,967,345	355,130,214	432,097,559			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	76,967,345	355,130,214	432,097,559			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:57 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
40.00	04000	SUBPROVIDER - IPF			40.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIAC	0.000000		76.00
76.01	03160	CARDIOPULMONARY	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINIC	0.000000		90.01
90.02	09002	DIABETES CLINIC	0.000000		90.02
90.03	09003	ASTHMA CLINIC	0.000000		90.03
90.04	09004	ANDIS CLINIC	0.000000		90.04
90.05	09005	PRIME TIME	0.000000		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000		90.06
90.07	04951	ONCOLOGY	0.000000		90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000		90.08
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part I Date/Time Prepared: 5/26/2022 3:57 pm

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	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,411,074	0	2,411,074	7,526	320.37	30.00
31.00	INTENSIVE CARE UNIT	1,782,478		1,782,478	6,388	279.04	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
200.00	Total (lines 30 through 199)	4,193,552		4,193,552	13,914		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,063	340,553	30.00
31.00	INTENSIVE CARE UNIT	1,792	500,040	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
200.00	Total (lines 30 through 199)	2,855	840,593	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/26/2022 3:57 pm

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		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	939,325	30,007,092	0.031303	2,525,739	79,063	50.00
51.00	05100	RECOVERY ROOM	228,049	2,551,709	0.089371	238,830	21,344	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,681,864	86,371,094	0.019473	2,713,468	52,839	54.00
60.00	06000	LABORATORY	427,228	59,640,177	0.007163	4,112,734	29,460	60.00
65.00	06500	RESPIRATORY THERAPY	388,739	12,763,588	0.030457	1,287,210	39,205	65.00
66.00	06600	PHYSICAL THERAPY	327,050	5,498,249	0.059483	243,096	14,460	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,879	1,370,666	0.004289	194,256	833	67.00
68.00	06800	SPEECH PATHOLOGY	2,729	785,682	0.003473	78,771	274	68.00
69.00	06900	ELECTROCARDIOLOGY	306,563	16,417,728	0.018673	1,670,805	31,199	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	287,927	1,727,538	0.166669	211,183	35,198	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	20,100	7,299,233	0.002754	1,040,301	2,865	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	700,820	97,270,479	0.007205	4,345,429	31,309	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	78,762	411,407	0.191445	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,011	0	0.000000	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	215,649	4,394,694	0.049070	1,921	94	90.01
90.02	09002	DIABETES CLINIC	690	18,223	0.037864	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	145,846	52,588	2.773370	0	0	90.04
90.05	09005	PRIME TIME	0	0	0.000000	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	586	0	0.000000	0	0	90.06
90.07	04951	ONCOLOGY	941,548	4,606,245	0.204407	9,014	1,843	90.07
90.08	04950	ANDERSON WOMENS CENTER	149,012	3,522,746	0.042300	516	22	90.08
91.00	09100	EMERGENCY	1,059,930	58,616,975	0.018082	3,685,163	66,635	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	965,581	14,771,789	0.065367	219,868	14,372	92.00
200.00		Total (lines 50 through 199)	8,880,888	408,097,902		22,578,304	421,015	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part III Date/Time Prepared: 5/26/2022 3:57 pm

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		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	7,526	0.00	1,063	30.00
31.00	03100	INTENSIVE CARE UNIT		0	6,388	0.00	1,792	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
200.00		Total (lines 30 through 199)		0	13,914		2,855	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/26/2022 3:57 pm

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	369,416	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	369,416	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/26/2022 3:57 pm

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		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	30,007,092	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,551,709	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	369,416	369,416	86,371,094	0.004277	54.00
60.00	06000	LABORATORY	0	0	0	59,640,177	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,763,588	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,498,249	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,370,666	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	785,682	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	16,417,728	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,727,538	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	7,299,233	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	97,270,479	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	411,407	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	0	0	4,394,694	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	0	0	18,223	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	0	0	52,588	0.000000	90.04
90.05	09005	PRIME TIME	0	0	0	3,974	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0.000000	90.06
90.07	04951	ONCOLOGY	0	0	0	4,606,245	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	3,522,746	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	58,616,975	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	14,771,789	0.000000	92.00
200.00		Total (lines 50 through 199)	0	369,416	369,416	408,101,876		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/26/2022 3:57 pm

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		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	2,525,739	0	4,829,659	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	238,830	0	253,218	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.004277	2,713,468	11,606	19,974,575	85,431	54.00
60.00	06000	LABORATORY	0.000000	4,112,734	0	5,853,712	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,287,210	0	1,566,627	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	243,096	0	25,105	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	194,256	0	9,712	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	78,771	0	38,044	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,670,805	0	2,809,264	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	211,183	0	282,807	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	1,040,301	0	1,051,358	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,345,429	0	25,106,559	0	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.000000	0	0	165,884	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.000000	1,921	0	1,561,097	0	90.01
90.02	09002	DIABETES CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0.000000	9,014	0	1,278,477	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000	516	0	132,548	0	90.08
91.00	09100	EMERGENCY	0.000000	3,685,163	0	6,912,830	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	219,868	0	3,051,946	0	92.00
200.00		Total (lines 50 through 199)		22,578,304	11,606	74,903,422	85,431	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 3:57 pm

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		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	0.265202	4,829,659	0	0	1,280,835	50.00
51.00	05100	RECOVERY ROOM	0.482031	253,218	0	0	122,059	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125548	19,974,575	0	0	2,507,768	54.00
60.00	06000	LABORATORY	0.128498	5,853,712	0	0	752,190	60.00
65.00	06500	RESPIRATORY THERAPY	0.292376	1,566,627	0	0	458,044	65.00
66.00	06600	PHYSICAL THERAPY	0.486943	25,105	0	0	12,225	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.374514	9,712	0	0	3,637	67.00
68.00	06800	SPEECH PATHOLOGY	0.303867	38,044	0	0	11,560	68.00
69.00	06900	ELECTROCARDIOLOGY	0.112835	2,809,264	0	0	316,983	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.952758	282,807	0	0	835,061	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.262946	1,051,358	0	0	276,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.231981	25,106,559	0	3,833	5,824,245	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.622590	165,884	0	0	103,278	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.237667	1,561,097	0	0	371,021	90.01
90.02	09002	DIABETES CLINIC	3.310651	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	9.419335	0	0	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0.839437	1,278,477	0	0	1,073,201	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.202101	132,548	0	0	26,788	90.08
91.00	09100	EMERGENCY	0.124014	6,912,830	0	0	857,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.360198	3,051,946	0	0	1,099,305	92.00
200.00		Subtotal (see instructions)		74,903,422	0	3,833	15,931,938	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		74,903,422	0	3,833	15,931,938	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 3:57 pm

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		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	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	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	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	889		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0		90.04
90.05	09005	PRIME TIME	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0		90.06
90.07	04951	ONCOLOGY	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0		90.08
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	889		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	889		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:57 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,526	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,526	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)	4,512	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 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)	1,063	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)	0	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,286,033	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)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,286,033	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)	13,286,033	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)	1,765.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,876,567	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)	1,876,567	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:57 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	11,514,546	6,388	1,802.53	1,792	3,230,134	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)	4,883,546	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,990,247	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)	840,593	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	432,621	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,273,214	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,717,033	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)	0	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)	0	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)	3,014	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,765.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,320,765	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:57 pm

Title XVIII | Hospital | PPS

	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	2,411,074	13,286,033	0.181474	5,320,765	965,581	90.00
91.00	Nursing Program cost	0	13,286,033	0.000000	5,320,765	0	91.00
92.00	Allied health cost	0	13,286,033	0.000000	5,320,765	0	92.00
93.00	All other Medical Education	0	13,286,033	0.000000	5,320,765	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:57 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,526	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,526	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)	4,512	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 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)	302	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)	0	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,286,033	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)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,286,033	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)	13,286,033	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)	1,765.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	533,136	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)	533,136	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:57 pm

Title XIX | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	11,514,546	6,388	1,802.53	0	0	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)	385,413	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	918,549	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)	0	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)	0	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)	3,014	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,765.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,320,765	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:57 pm

Title XIX | 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	2,411,074	13,286,033	0.181474	5,320,765	965,581	90.00
91.00	Nursing Program cost	0	13,286,033	0.000000	5,320,765	0	91.00
92.00	Allied health cost	0	13,286,033	0.000000	5,320,765	0	92.00
93.00	All other Medical Education	0	13,286,033	0.000000	5,320,765	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 3:57 pm

Title XVIII | Hospital | PPS

		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		1,045,707		30.00
31.00	03100	INTENSIVE CARE UNIT		4,655,876		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.265202	2,525,739	669,831	50.00
51.00	05100	RECOVERY ROOM	0.482031	238,830	115,123	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125548	2,713,468	340,670	54.00
60.00	06000	LABORATORY	0.128498	4,112,734	528,478	60.00
65.00	06500	RESPIRATORY THERAPY	0.292376	1,287,210	376,349	65.00
66.00	06600	PHYSICAL THERAPY	0.486943	243,096	118,374	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.374514	194,256	72,752	67.00
68.00	06800	SPEECH PATHOLOGY	0.303867	78,771	23,936	68.00
69.00	06900	ELECTROCARDIOLOGY	0.112835	1,670,805	188,525	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.952758	211,183	623,572	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.262946	1,040,301	273,543	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.231981	4,345,429	1,008,057	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.622590	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.237667	1,921	457	90.01
90.02	09002	DIABETES CLINIC	3.310651	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	9.419335	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	90.06
90.07	04951	ONCOLOGY	0.839437	9,014	7,567	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.202101	516	104	90.08
91.00	09100	EMERGENCY	0.124014	3,685,163	457,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.360198	219,868	79,196	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		22,578,304	4,883,546	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)		22,578,304		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 3:57 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		402,799		30.00
31.00	03100	INTENSIVE CARE UNIT		429,698		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.265202	337,148	89,412	50.00
51.00	05100	RECOVERY ROOM	0.482031	37,158	17,911	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125548	103,275	12,966	54.00
60.00	06000	LABORATORY	0.128498	285,429	36,677	60.00
65.00	06500	RESPIRATORY THERAPY	0.292376	135,392	39,585	65.00
66.00	06600	PHYSICAL THERAPY	0.486943	9,524	4,638	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.374514	7,990	2,992	67.00
68.00	06800	SPEECH PATHOLOGY	0.303867	5,562	1,690	68.00
69.00	06900	ELECTROCARDIOLOGY	0.112835	85,747	9,675	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.952758	12,920	38,150	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.262946	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.231981	477,789	110,838	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.622590	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.237667	486	116	90.01
90.02	09002	DIABETES CLINIC	3.310651	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	9.419335	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	90.06
90.07	04951	ONCOLOGY	0.839437	159	133	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.202101	0	0	90.08
91.00	09100	EMERGENCY	0.124014	166,353	20,630	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.360198	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,664,932	385,413	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)		1,664,932		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 3:57 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,281,937	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,731,968	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	32,289	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	86.34	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.33	30.00
31.00	Percentage of Medicaid patient days (see instructions)	16.03	31.00
32.00	Sum of lines 30 and 31	17.36	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.04	33.00
34.00	Disproportionate share adjustment (see instructions)	70,841	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Date/Time Prepared: 5/26/2022 3:57 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,619,884	1,311,318	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,211,584	330,524	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,542,108		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	8,659,143		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	8,659,143	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	532,642	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	4,348	53.00
54.00	Special add-on payments for new technologies	216,356	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	11,606	58.00
59.00	Total (sum of amounts on lines 49 through 58)	9,424,095	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	9,424,095	61.00
62.00	Deductibles billed to program beneficiaries	911,976	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	12,313	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	8,003	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	8,520,122	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	35,937	70.93
70.94	HRR adjustment amount (see instructions)	-2,169	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Date/Time Prepared: 5/26/2022 3:57 pm

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2021	762,469	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2022	253,939	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,570,298	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		9,116,951	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		453,347	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		115,433	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/26/2022 3:57 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,281,937	0	5,281,937		5,281,937	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,731,968	0		1,731,968	1,731,968	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	32,289	0	32,289		32,289	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0404	0.0404	0.0404	0.0404		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	70,841	0	53,348	17,493	70,841	11.00
11.01	Uncompensated care payments	36.00	1,542,108	0	1,211,584	330,524	1,542,108	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,659,143	0	6,579,158	2,079,985	8,659,143	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,659,143	0	6,579,158	2,079,985	8,659,143	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	532,642	0	405,207	127,435	532,642	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/26/2022 3:57 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	216,356	0	143,512	72,844	216,356	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	7,127,877	2,280,264	9,408,141	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	526,247	0	399,177	127,070	526,247	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,395	0	6,030	365	6,395	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	532,642	0	405,207	127,435	532,642	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.106970	0.111364		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			762,469		762,469	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				253,939	253,939	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2022 3:57 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,281,937	5,281,937		5,281,937	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,731,968		1,731,968	1,731,968	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	32,289	32,289		32,289	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0404	0.0404	0.0404		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	70,841	53,348	17,493	70,841	11.00
11.01	Uncompensated care payments	36.00	1,542,108	1,211,584	330,524	1,542,108	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,659,143	6,579,158	2,079,985	8,659,143	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,659,143	6,579,158	2,079,985	8,659,143	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	532,642	405,207	127,435	532,642	16.00
17.00	Special add-on payments for new technologies	54.00	216,356	143,511	72,845	216,356	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			7,127,876	2,280,265	9,408,141	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2022 3:57 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	526,247	399,177	127,070	526,247	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,395	6,030	365	6,395	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	532,642	405,207	127,435	532,642	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	762,469	762,469		762,469	28.00
29.00	Low volume adjustment on or after October 1	70.97	253,939		253,939	253,939	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	35,937	35,937	0	35,937	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-2,169	-1,628	-541	-2,169	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 3:57 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	889	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	15,846,507	2.00
3.00	OPPS payments	11,614,277	3.00
4.00	Outlier payment (see instructions)	56,415	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	85,431	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	889	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,833	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)	3,833	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)	3,833	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,944	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)	889	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)	11,756,123	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,941,642	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)	9,815,370	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	9,815,370	30.00
31.00	Primary payer payments	566	31.00
32.00	Subtotal (line 30 minus line 31)	9,814,804	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)	20,421	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	13,274	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	9,828,078	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-50	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)	9,828,128	40.00
40.01	Sequestration adjustment (see instructions)	0	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	9,930,678	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)	-102,550	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: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2022 3:57 pm

Title XVIII | Hospital | PPS

		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		9,116,951		9,728,583	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	12/31/2021	202,095	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		202,095	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)		9,116,951		9,930,678	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		453,347		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		102,550	6.02
7.00	Total Medicare program liability (see instructions)		9,570,298		9,828,128	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: 15-0037	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/26/2022 3:57 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		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 | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-3 Part VII | Date/Time Prepared: 5/26/2022 3:57 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	918,549		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	918,549	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	918,549	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	832,497		8.00
9.00	Ancillary service charges	1,664,932	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	2,497,429	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	2,497,429	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,578,880	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	918,549	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	918,549	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	918,549	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	918,549	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	918,549	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	918,549	0	40.00
41.00	Interim payments	1,041,994	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-123,445	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/26/2022 3:57 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	10,816,991	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,139,736	0	0	0	4.00
5.00	Other receivable	23,525,014	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	4,493,624	0	0	0	7.00
8.00	Prepaid expenses	2,238,424	0	0	0	8.00
9.00	Other current assets	123,952,195	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)	183,165,984	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	28,712,482	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	175,428,138	0	0	0	15.00
16.00	Accumulated depreciation	-181,768,888	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	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	95,936,993	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	118,308,725	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	41,910,436	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	41,910,436	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	343,385,145	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,924,050	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,107,186	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	9,294,480	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,325,716	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,325,716	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	321,059,429				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)	321,059,429	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	343,385,145	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/26/2022 3:57 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		307,522,253		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,537,176				2.00
3.00	Total (sum of line 1 and line 2)		321,059,429		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)		321,059,429		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)		321,059,429		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: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2022 3:57 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,610,539		7,610,539	1.00
2.00	SUBPROVIDER - IPF	0		0	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)	7,610,539		7,610,539	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	15,036,229		15,036,229	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)	15,036,229		15,036,229	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,646,768		22,646,768	17.00
18.00	Ancillary services	52,958,067	364,528,765	417,486,832	18.00
19.00	Outpatient services	0	27,412	27,412	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	956,819	1,479,077	2,435,896	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)	76,561,654	366,035,254	442,596,908	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		160,378,987		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)		160,378,987		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-3 | Date/Time Prepared: 5/26/2022 3:57 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	442,596,908	1.00
2.00	Less contractual allowances and discounts on patients' accounts	301,940,557	2.00
3.00	Net patient revenues (line 1 minus line 2)	140,656,351	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	160,378,987	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-19,722,636	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	12,594,526	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	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	18,647,031	24.00
24.01	OTHER NON-OPERATING INCOME	3,888,441	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	35,129,998	25.00
26.00	Total (line 5 plus line 25)	15,407,362	26.00
27.00	GAIN/LOSS	1,870,186	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1,870,186	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	13,537,176	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0037	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/26/2022 3:57 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	526,247	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	6,395	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	30.16	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	532,642	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 3:57 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	19,343	0	19,343	0	19,343	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	141,578	0	141,578	0	141,578	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	48,182	0	48,182	0	48,182	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	57,552	0	57,552	0	57,552	9.00
10.00	Subtotal (sum of lines 1 through 9)	266,655	0	266,655	0	266,655	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	266,655	0	266,655	0	266,655	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	37,045	37,045	-37,045	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	37,045	37,045	-37,045	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	236,864	236,864	0	236,864	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	236,864	236,864	0	236,864	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	266,655	273,909	540,564	-37,045	503,519	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-1 | Date/Time Prepared: 5/26/2022 3:57 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	19,343		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	141,578		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	48,182		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	57,552		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	266,655		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	266,655		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	236,864		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	236,864		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	503,519		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-2 | Date/Time Prepared: 5/26/2022 3:57 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.08	152	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.04	3,689	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.12	3,841		1	3,841	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.12	3,841			3,841	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					266,655	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					266,655	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					236,864	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					131,496	15.00
16.00	Total overhead (sum of lines 14 and 15)					368,360	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					368,360	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					368,360	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					635,015	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2021 To 12/31/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 3:57 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		635,015	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		38,434	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		596,581	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,841	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,841	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		155.32	7.00
		Calculation of Limit (1)		
		Rate Period 1 (01/01/2021 through 03/31/2021)	Rate Period 2 (04/01/2021 through 12/31/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	87.52	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	87.52	100.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	50	202	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	4,376	20,200	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	24,576	16.00
16.01	Total program charges (see instructions)(from contractor's records)		34,685	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,354	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,794	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		11,134	16.04
16.05	Total program cost (see instructions)	0	14,928	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,864	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,493	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		14,928	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,802	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		25,730	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		25,730	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		14,028	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		11,702	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2021 To 12/31/2021 | Worksheet M-4 | Date/Time Prepared: 5/26/2022 3:57 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	266,655	266,655	266,655	266,655	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.004703	0.025998	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,254	6,932	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5,235	2,718	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	6,489	9,650	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	266,655	266,655	266,655	266,655	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	368,360	368,360	368,360	368,360	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.024335	0.036189	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	8,964	13,331	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	15,453	22,981	0	0	10.00
11.00	Total number of injections/infusions (from your records)	36	168	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	429.25	136.79	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	7	57	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	3,005	7,797	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		38,434			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		10,802			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 3:57 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		14,028	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	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		14,028	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			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		11,702	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		25,730	7.00

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