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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/31/2022 11:29 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/31/2022 Time: 11:29 am
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 HARRISON COUNTY HOSPITAL (15-1331) 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	Charles Wiley		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	Charles Wiley			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	-117,632	-324,247	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	45,047	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-72,585	-324,247	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 11:29 am

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

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

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2021	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.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
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.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2022 11:29 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. 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: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 11:29 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 11:29 am

		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: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2022 11:29 am

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 11:29 am

				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	Y	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	505,633	0	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		Y	5.01		122.00
	Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2022 11:29 am

		1.00	2.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	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: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 11:29 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2022 11:29 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for 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.	N		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	03/21/2022	Y	03/21/2022	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: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2022 11:29 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CLINT		BRILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND COMPANY				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502.992.3512		CBRILL@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/31/2022 11:29 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2022 11:29 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	71,808.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	71,808.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	71,808.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2022 11:29 am

	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)	858	64	2,992			1.00
2.00	HMO and other (see instructions)	527	1,132				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	84	0	84			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)	942	64	3,076			7.00
8.00	INTENSIVE CARE UNIT	216	0	563			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		37	772			13.00
14.00	Total (see instructions)	1,158	101	4,411	0.00	488.47	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	488.47	27.00
28.00	Observation Bed Days		20	947			28.00
29.00	Ambulance Trips	1,788					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2022 11:29 am

	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	249	21	944	1.00
2.00	HMO and other (see instructions)			103	251		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	249	21	944	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/31/2022 11:29 am

		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)	0.261772	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,184,020	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	29,704,418	6.00
7.00	Medicaid cost (line 1 times line 6)	7,775,785	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)	0	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)	0	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)	554,160	1,469,006	2,023,166	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	145,064	1,469,006	1,614,070	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)	145,064	1,469,006	1,614,070	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)	5,257,687	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	520,063	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	800,098	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,457,589	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,446,907	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,060,977	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,060,977	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,534,869	1,534,869	198,354	1,733,223	1.00
1.01	00101	MOB		620,393	620,393	0	620,393	1.01
1.02	00102	AMB DEPR		0	0	58,866	58,866	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		994,291	994,291	3,970	998,261	2.00
2.01	00201	AMB EQUIP		0	0	246,438	246,438	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	192,063	1,045,172	1,237,235	210,751	1,447,986	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	1,681,232	4,977,926	6,659,158	-708	6,658,450	5.01
5.02	00570	ADMITTING	516,455	168,927	685,382	0	685,382	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	395,285	896,915	1,292,200	0	1,292,200	5.03
7.00	00700	OPERATION OF PLANT	264,804	1,334,645	1,599,449	0	1,599,449	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,289	238,991	262,280	0	262,280	8.00
9.00	00900	HOUSEKEEPING	529,169	325,728	854,897	0	854,897	9.00
10.00	01000	DIETARY	456,214	441,372	897,586	-516,202	381,384	10.00
11.00	01100	CAFETERIA	0	0	0	516,202	516,202	11.00
13.00	01300	NURSING ADMINISTRATION	691,198	216,452	907,650	0	907,650	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	218,416	2,350,642	2,569,058	-1,549,625	1,019,433	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	645,573	315,258	960,831	-585	960,246	16.00
17.00	01700	SOCIAL SERVICE	299,647	88,113	387,760	0	387,760	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,777,939	1,554,999	5,332,938	-193,115	5,139,823	30.00
31.00	03100	INTENSIVE CARE UNIT	477,684	152,233	629,917	-7,231	622,686	31.00
43.00	04300	NURSERY	0	179	179	166,425	166,604	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,006,361	776,632	1,782,993	-256,908	1,526,085	50.00
53.00	05300	ANESTHESIOLOGY	0	1,221,262	1,221,262	-14,338	1,206,924	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,067,108	1,025,644	2,092,752	-87,142	2,005,610	54.00
60.00	06000	LABORATORY	848,577	1,765,606	2,614,183	-175,297	2,438,886	60.00
65.00	06500	RESPIRATORY THERAPY	0	595,094	595,094	-74,017	521,077	65.00
66.00	06600	PHYSICAL THERAPY	371,367	67,859	439,226	-56,930	382,296	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	48,836	48,836	67.00
68.00	06800	SPEECH PATHOLOGY	0	46	46	8,038	8,084	68.00
69.00	06900	ELECTROCARDIOLOGY	460,503	167,042	627,545	23,633	651,178	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,815,400	1,815,400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	916,554	916,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	349,315	2,083,791	2,433,106	-183	2,432,923	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	24,483	15,868	40,351	-7,674	32,677	90.00
90.01	09001	SENIOR CARE	84,871	137,891	222,762	0	222,762	90.01
90.02	09002	GENERAL SURGERY	809,036	300,666	1,109,702	-1,767	1,107,935	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	577,979	277,275	855,254	-19,063	836,191	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	518,135	254,763	772,898	-23,288	749,610	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	1,259,659	629,795	1,889,454	-351,688	1,537,766	90.05
90.06	09006	OBGYN - DR SAUER	531,396	236,146	767,542	-4,759	762,783	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	0	0	1,209,827	1,209,827	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	0	0	389,062	389,062	90.08
90.09	09009	PAIN MANAGEMENT	159,479	33,653	193,132	-12,927	180,205	90.09
90.10	09010	DERMATOLOGY	475,298	146,197	621,495	-3,591	617,904	90.10
91.00	09100	EMERGENCY	1,813,134	833,798	2,646,932	-16,030	2,630,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,225,802	1,675,393	3,901,195	-537,654	3,363,541	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		171,766	171,766	-171,766	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,751,471	29,673,292	52,424,763	1,729,868	54,154,631	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,735,077	3,333,859	8,068,936	-1,729,868	6,339,068	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	360,156	212,663	572,819	0	572,819	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	27,846,704	33,219,814	61,066,518	0	61,066,518	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/31/2022 11:29 am

		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	-27,357	1,705,866		1.00
1.01	00101	MOB	0	620,393		1.01
1.02	00102	AMB DEPR	0	58,866		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	998,261		2.00
2.01	00201	AMB EQUIP	0	246,438		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-47,085	1,400,901		4.00
5.01	00590	ADMINISTRATIVE & GENERAL	-1,536,030	5,122,420		5.01
5.02	00570	ADMITTING	0	685,382		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,292,200		5.03
7.00	00700	OPERATION OF PLANT	0	1,599,449		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	262,280		8.00
9.00	00900	HOUSEKEEPING	0	854,897		9.00
10.00	01000	DIETARY	0	381,384		10.00
11.00	01100	CAFETERIA	-124,341	391,861		11.00
13.00	01300	NURSING ADMINISTRATION	0	907,650		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,019,433		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,271	946,975		16.00
17.00	01700	SOCIAL SERVICE	0	387,760		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	5,139,823		30.00
31.00	03100	INTENSIVE CARE UNIT	0	622,686		31.00
43.00	04300	NURSERY	0	166,604		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,526,085		50.00
53.00	05300	ANESTHESIOLOGY	-1,191,120	15,804		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,005,610		54.00
60.00	06000	LABORATORY	-3,648	2,435,238		60.00
65.00	06500	RESPIRATORY THERAPY	-1,921	519,156		65.00
66.00	06600	PHYSICAL THERAPY	0	382,296		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	48,836		67.00
68.00	06800	SPEECH PATHOLOGY	0	8,084		68.00
69.00	06900	ELECTROCARDIOLOGY	0	651,178		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,815,400		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	916,554		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,432,923		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	32,677		90.00
90.01	09001	SENIOR CARE	-17,444	205,318		90.01
90.02	09002	GENERAL SURGERY	-836,588	271,347		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	-438,120	398,071		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	-471,524	278,086		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	-1,225,835	311,931		90.05
90.06	09006	OBGYN - DR SAUER	-603,634	159,149		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	-312,781	897,046		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	-198,239	190,823		90.08
90.09	09009	PAIN MANAGEMENT	-185,883	-5,678		90.09
90.10	09010	DERMATOLOGY	-411,654	206,250		90.10
91.00	09100	EMERGENCY	0	2,630,902		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-14,078	3,349,463		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,660,553	46,494,078		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,339,068		192.00
194.00	07950	MARKETING	0	0		194.00
194.01	07951	PHYSICIAN BILLING	0	572,819		194.01
194.02	07952	MOB	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,660,553	53,405,965		200.00

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/31/2022 11:29 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,731,954	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
24.00		0.00	0	0	24.00
	0		0	2,731,954	
	B - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	916,554	1.00
	0		0	916,554	
	C - AMBULANCE CAPITAL				
1.00	AMB DEPR	1.02	0	58,866	1.00
2.00	AMB EQUIP	2.01	0	246,438	2.00
	0		0	305,304	
	D - INTEREST				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	171,766	1.00
	0		0	171,766	
	E - EKG				
1.00	ELECTROCARDIOLOGY	69.00	14,800	19,483	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
	0		14,800	19,483	
	F - NURSERY				
1.00	NURSERY	43.00	166,443	0	1.00
	0		166,443	0	
	G - THERAPY				
1.00	SPEECH PATHOLOGY	68.00	6,796	1,242	1.00
2.00	OCCUPATIONAL THERAPY	67.00	41,296	7,540	2.00
	0		48,092	8,782	
	H - CAFETERIA				
1.00	CAFETERIA	11.00	262,369	253,833	1.00
	0		262,369	253,833	
	I - DEPRECIATION RECLASS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26,588	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,970	2.00
	TOTALS		0	30,558	
	J - AMBULANCE WORKERS COMP				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	184,389	1.00
	TOTALS		0	184,389	
	K - MISCELLANEOUS BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26,362	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	26,362	
	L - FCMG PROVIDER BASED				
1.00	FIRST CAPITAL MEDICAL GROUP	90.07	856,664	397,571	1.00
	TOTALS		856,664	397,571	

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/31/2022 11:29 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	M - SHFM PROVIDER BASED					
1.00	SOUTH HARRISON FAMILY MEDICINE	90.08	286,311	133,695		1.00
	TOTALS		286,311	133,695		
500.00	Grand Total: Increases		1,634,679	5,180,251		500.00

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/31/2022 11:29 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,549,625	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	26,672	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	7,231	0		3.00
4.00	NURSERY	43.00	0	18	0		4.00
5.00	OPERATING ROOM	50.00	0	256,908	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	14,338	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	87,142	0		7.00
8.00	LABORATORY	60.00	0	161,090	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	54,534	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	56	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	10,650	0		11.00
12.00	DRUGS CHARGED TO PATIENTS	73.00	0	183	0		12.00
13.00	CLINIC	90.00	0	7,674	0		13.00
14.00	GENERAL SURGERY	90.02	0	1,767	0		14.00
15.00	HARRISON CRAWFORD HEALTHCARE	90.03	0	19,063	0		15.00
16.00	CORYDON MEDICAL ASSOCIATES	90.04	0	23,288	0		16.00
17.00	ORTHOPEDIC SURGERY - DR KLINE	90.05	0	351,688	0		17.00
18.00	OBGYN - DR SAUER	90.06	0	4,759	0		18.00
19.00	FIRST CAPITAL MEDICAL GROUP	90.07	0	44,408	0		19.00
20.00	SOUTH HARRISON FAMILY MEDICINE	90.08	0	30,944	0		20.00
21.00	PAIN MANAGEMENT	90.09	0	12,927	0		21.00
22.00	DERMATOLOGY	90.10	0	3,591	0		22.00
23.00	EMERGENCY	91.00	0	15,507	0		23.00
24.00	AMBULANCE SERVICES	95.00	0	47,891	0		24.00
	0		0	2,731,954			
	B - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	916,554	0		1.00
	0		0	916,554			
	C - AMBULANCE CAPITAL						
1.00	AMBULANCE SERVICES	95.00	0	305,304	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	305,304			
	D - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	171,766	11		1.00
	0		0	171,766			
	E - EKG						
1.00	LABORATORY	60.00	14,207	0	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	19,483	0		2.00
3.00	EMERGENCY	91.00	523	0	0		3.00
4.00	AMBULANCE SERVICES	95.00	70	0	0		4.00
	0		14,800	19,483			
	F - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	166,443	0	0		1.00
	0		166,443	0			
	G - THERAPY						
1.00	PHYSICAL THERAPY	66.00	48,092	8,782	0		1.00
2.00		0.00	0	0	0		2.00
	0		48,092	8,782			
	H - CAFETERIA						
1.00	DIETARY	10.00	262,369	253,833	0		1.00
	0		262,369	253,833			
	I - DEPRECIATION RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	30,558	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	30,558			
	J - AMBULANCE WORKERS COMP						
1.00	AMBULANCE SERVICES	95.00	0	184,389	0		1.00
	TOTALS		0	184,389			
	K - MISCELLANEOUS BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.01	0	708	0		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	585	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	25,069	0		3.00
	TOTALS		0	26,362			
	L - FCMG PROVIDER BASED						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	856,664	397,571	0		1.00
	TOTALS		856,664	397,571			
	M - SHFM PROVIDER BASED						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	286,311	133,695	0		1.00
	TOTALS		286,311	133,695			
500.00	Grand Total: Decreases		1,634,679	5,180,251			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I Date/Time Prepared: 5/31/2022 11:29 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,001,138	0	0	0	0	1.00
2.00	Land Improvements	3,379,433	0	0	0	23,557	2.00
3.00	Buildings and Fixtures	41,615,649	0	0	0	4,151,285	3.00
4.00	Building Improvements	3,605,135	0	0	0	2,747,863	4.00
5.00	Fixed Equipment	0	346,074	0	346,074	0	5.00
6.00	Movable Equipment	28,709,252	0	0	0	581,143	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	80,310,607	346,074	0	346,074	7,503,848	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	80,310,607	346,074	0	346,074	7,503,848	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,001,138	0	1.00
2.00	Land Improvements	3,355,876	0	2.00
3.00	Buildings and Fixtures	37,464,364	0	3.00
4.00	Building Improvements	857,272	0	4.00
5.00	Fixed Equipment	346,074	0	5.00
6.00	Movable Equipment	28,128,109	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	73,152,833	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	73,152,833	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II Date/Time Prepared: 5/31/2022 11:29 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,436,514	0	0	98,355	0	1.00
1.01	MOB	297,913	81,701	73,477	0	0	1.01
1.02	AMB DEPR	0	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	994,291	0	0	0	0	2.00
2.01	AMB EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,728,718	81,701	73,477	98,355	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,534,869	1.00
1.01	MOB	167,302	620,393	1.01
1.02	AMB DEPR	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	994,291	2.00
2.01	AMB EQUIP	0	0	2.01
3.00	Total (sum of lines 1-2)	167,302	3,149,553	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2022 11:29 am

	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	45,024,724	0	45,024,724	0.615488	0	1.00
1.01	MOB	0	0	0	0.000000	0	1.01
1.02	AMB DEPR	0	0	0	0.000000	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	28,128,109	0	28,128,109	0.384512	0	2.00
2.01	AMB EQUIP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	73,152,833	0	73,152,833	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,463,102	0	1.00
1.01	MOB	0	0	0	297,913	81,701	1.01
1.02	AMB DEPR	0	0	0	58,866	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	998,261	0	2.00
2.01	AMB EQUIP	0	0	0	246,438	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	3,064,580	81,701	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	144,409	98,355	0	0	1,705,866	1.00
1.01	MOB	73,477	0	0	167,302	620,393	1.01
1.02	AMB DEPR	0	0	0	0	58,866	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	998,261	2.00
2.01	AMB EQUIP	0	0	0	0	246,438	2.01
3.00	Total (sum of lines 1-2)	217,886	98,355	0	167,302	3,629,824	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/31/2022 11:29 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - MOB (chapter 2)		0	MOB	1.01	0	1.01
1.02	Investment income - AMB DEPR (chapter 2)		0	AMB DEPR	1.02	0	1.02
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - AMB EQUIP (chapter 2)		0	AMB EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,989	ADMINISTRATIVE & GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,868,844			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	-124,341	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-13,271	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - MOB		0	MOB	1.01	0	26.01
26.02	Depreciation - AMB DEPR		0	AMB DEPR	1.02	0	26.02

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/31/2022 11:29 am

	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	
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - AMB EQUIP		0	AMB EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME - A&G	B	-43,677	ADMINISTRATIVE & GENERAL	5.01	0	33.00
33.01	MISC INCOME - LABORATORY	B	-348	LABORATORY	60.00	0	33.01
33.02	CLINIC RENT	A	-17,444	SENIOR CARE	90.01	0	33.02
33.03	CLINIC RENT	A	-76,914	GENERAL SURGERY	90.02	0	33.03
33.04	CLINIC RENT	A	-91,327	HARRISON CRAWFORD HEALTHCARE	90.03	0	33.04
33.05	CLINIC RENT	A	-91,890	CORYDON MEDICAL ASSOCIATES	90.04	0	33.05
33.06	CLINIC RENT	A	-135,852	FIRST CAPITAL MEDICAL GROUP	90.07	0	33.06
33.07	CLINIC RENT	A	-52,600	SOUTH HARRISON FAMILY MEDICINE	90.08	0	33.07
33.08	CLINIC RENT	A	-68,051	ORTHOPEDIC SURGERY - DR KLINE	90.05	0	33.08
33.09	CLINIC RENT	A	-46,224	OBGYN - DR SAUER	90.06	0	33.09
33.10	FOUNDATION SALARY	B	-30,261	ADMINISTRATIVE & GENERAL	5.01	0	33.10
34.00	INTEREST	B	-18,696	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	34.00
34.01	PROVIDER TAX FEE	A	-1,307,198	ADMINISTRATIVE & GENERAL	5.01	0	34.01
35.00	UNNECESSARY BORROWING	A	-8,661	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	35.00
36.00	CRNA	A	-1,191,120	ANESTHESIOLOGY	53.00	0	36.00
37.00	LOBBYING FEES	A	-6,611	ADMINISTRATIVE & GENERAL	5.01	0	37.00
38.00	MARKETING EXPENSE	A	-145,294	ADMINISTRATIVE & GENERAL	5.01	0	38.00
39.00	NURSE PRACTITIONER OFFSET - SALARY	A	-85,035	HARRISON CRAWFORD HEALTHCARE	90.03	0	39.00
40.00	NURSE PRACTITIONER OFFSET - SALARY	A	-96,571	CORYDON MEDICAL ASSOCIATES	90.04	0	40.00
40.01	NURSE PRACTITIONER OFFSET - SALARY	A	-90,249	ORTHOPEDIC SURGERY - DR KLINE	90.05	0	40.01
41.00	NURSE PRACTITIONER OFFSET - BENEFITS	A	-47,085	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,660,553				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2022 11:29 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	17.00	SOCIAL SERVICE	117,654	0	117,654	0	0	1.00
2.00	60.00	LABORATORY	32,995	3,300	29,695	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	1,921	1,921	0	0	0	3.00
4.00	90.02	GENERAL SURGERY	761,479	759,674	1,805	0	0	4.00
5.00	90.03	HARRISON CRAWFORD HEALTHCARE	261,758	261,758	0	0	0	5.00
6.00	90.04	CORYDON MEDICAL ASSOCIATES	283,063	283,063	0	0	0	6.00
7.00	90.05	ORTHOPEDIC SURGERY - DR KLINE	1,076,176	1,067,535	8,641	0	0	7.00
8.00	90.06	OBGYN - DR SAUER	557,410	557,410	0	0	0	8.00
9.00	90.07	FIRST CAPITAL MEDICAL GROUP	194,939	176,929	18,010	0	0	9.00
10.00	90.08	SOUTH HARRISON FAMILY MEDICINE	145,639	145,639	0	0	0	10.00
11.00	90.09	PAIN MANAGEMENT	185,883	185,883	0	0	0	11.00
12.00	90.10	DERMATOLOGY	411,654	411,654	0	0	0	12.00
13.00	91.00	EMERGENCY	299,279	0	299,279	0	0	13.00
14.00	95.00	AMBULANCE SERVICES	14,078	14,078	0	0	0	14.00
200.00			4,343,928	3,868,844	475,084		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	17.00	SOCIAL SERVICE	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	90.02	GENERAL SURGERY	0	0	0	0	0	4.00
5.00	90.03	HARRISON CRAWFORD HEALTHCARE	0	0	0	0	0	5.00
6.00	90.04	CORYDON MEDICAL ASSOCIATES	0	0	0	0	0	6.00
7.00	90.05	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	0	0	7.00
8.00	90.06	OBGYN - DR SAUER	0	0	0	0	0	8.00
9.00	90.07	FIRST CAPITAL MEDICAL GROUP	0	0	0	0	0	9.00
10.00	90.08	SOUTH HARRISON FAMILY MEDICINE	0	0	0	0	0	10.00
11.00	90.09	PAIN MANAGEMENT	0	0	0	0	0	11.00
12.00	90.10	DERMATOLOGY	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
14.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	14.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	17.00	SOCIAL SERVICE	0	0	0	0		1.00
2.00	60.00	LABORATORY	0	0	0	3,300		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	1,921		3.00
4.00	90.02	GENERAL SURGERY	0	0	0	759,674		4.00
5.00	90.03	HARRISON CRAWFORD HEALTHCARE	0	0	0	261,758		5.00
6.00	90.04	CORYDON MEDICAL ASSOCIATES	0	0	0	283,063		6.00
7.00	90.05	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	1,067,535		7.00
8.00	90.06	OBGYN - DR SAUER	0	0	0	557,410		8.00
9.00	90.07	FIRST CAPITAL MEDICAL GROUP	0	0	0	176,929		9.00
10.00	90.08	SOUTH HARRISON FAMILY MEDICINE	0	0	0	145,639		10.00
11.00	90.09	PAIN MANAGEMENT	0	0	0	185,883		11.00
12.00	90.10	DERMATOLOGY	0	0	0	411,654		12.00
13.00	91.00	EMERGENCY	0	0	0	0		13.00
14.00	95.00	AMBULANCE SERVICES	0	0	0	14,078		14.00
200.00			0	0	0	3,868,844		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2022 11:29 am

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

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	8,760.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.66	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.83	34.83	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		610,222	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		610,222	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		610,222	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		610,222	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		0	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		0	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2022 11:29 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.66	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	610,222	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	610,222	63.00
64.00	Total cost of outside supplier services (from your records)	487,684	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,705,866	1,705,866				1.00
1.01	00101	MOB	620,393	0	620,393			1.01
1.02	00102	AMB DEPR	58,866	0	0	58,866		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	998,261				998,261	2.00
2.01	00201	AMB EQUIP	246,438				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,400,901	2,515	0	0	1,472	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	5,122,420	252,861	3,731	0	147,973	5.01
5.02	00570	ADMITTING	685,382	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,292,200	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	1,599,449	197,249	0	0	115,429	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	262,280	11,517	0	0	6,740	8.00
9.00	00900	HOUSEKEEPING	854,897	24,669	0	0	14,436	9.00
10.00	01000	DIETARY	381,384	71,781	0	0	42,006	10.00
11.00	01100	CAFETERIA	391,861	35,859	0	0	20,984	11.00
13.00	01300	NURSING ADMINISTRATION	907,650	6,035	0	0	3,532	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,019,433	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	946,975	40,046	0	0	23,435	16.00
17.00	01700	SOCIAL SERVICE	387,760	2,414	0	0	1,413	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,139,823	272,636	0	0	159,541	30.00
31.00	03100	INTENSIVE CARE UNIT	622,686	36,425	0	0	21,316	31.00
43.00	04300	NURSERY	166,604	7,544	0	0	4,415	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,526,085	222,824	0	0	130,395	50.00
53.00	05300	ANESTHESIOLOGY	15,804	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,005,610	116,743	0	0	68,317	54.00
60.00	06000	LABORATORY	2,435,238	61,358	5,824	0	35,906	60.00
65.00	06500	RESPIRATORY THERAPY	519,156	13,353	0	0	7,814	65.00
66.00	06600	PHYSICAL THERAPY	382,296	45,176	0	0	26,437	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,836	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,084	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	651,178	22,934	0	0	13,421	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,815,400	54,769	0	0	32,051	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	916,554	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,432,923	15,415	0	0	9,021	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	32,677	9,556	0	0	5,592	90.00
90.01	09001	SENIOR CARE	205,318	0	10,849	0	0	90.01
90.02	09002	GENERAL SURGERY	271,347	0	14,466	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	398,071	0	65,477	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	278,086	0	78,001	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	311,931	0	100,176	0	0	90.05
90.06	09006	OBGYN - DR SAUER	159,149	0	30,055	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	897,046	0	56,893	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	190,823	0	33,671	0	0	90.08
90.09	09009	PAIN MANAGEMENT	-5,678	0	22,841	0	0	90.09
90.10	09010	DERMATOLOGY	206,250	0	25,087	0	0	90.10
91.00	09100	EMERGENCY	2,630,902	82,468	0	0	48,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,349,463	0	0	58,866	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,494,078	1,606,147	447,071	58,866	939,906	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,247	0	0	5,997	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,339,068	83,185	0	0	48,679	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	572,819	6,287	0	0	3,679	194.01
194.02	07952	MOB	0	0	173,322	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	53,405,965	1,705,866	620,393	58,866	998,261	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	ADMITTING	
			2.01	4.00	4A	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP	246,438					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,404,888				4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	85,408	5,612,393	5,612,393		5.01
5.02	00570	ADMITTING	0	26,236	711,618	83,565	795,183	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	20,081	1,312,281	154,101	0	5.03
7.00	00700	OPERATION OF PLANT	0	13,452	1,925,579	226,121	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,183	281,720	33,082	0	8.00
9.00	00900	HOUSEKEEPING	0	26,882	920,884	108,139	0	9.00
10.00	01000	DIETARY	0	9,848	505,019	59,304	0	10.00
11.00	01100	CAFETERIA	0	13,329	462,033	54,257	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	35,114	952,331	111,832	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,096	1,030,529	121,015	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32,796	1,043,252	122,509	0	16.00
17.00	01700	SOCIAL SERVICE	0	15,222	406,809	47,772	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	183,472	5,755,472	675,865	41,822	30.00
31.00	03100	INTENSIVE CARE UNIT	0	24,267	704,694	82,752	7,102	31.00
43.00	04300	NURSERY	0	8,455	187,018	21,962	7,457	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	51,124	1,930,428	226,690	64,991	50.00
53.00	05300	ANESTHESIOLOGY	0	0	15,804	1,856	13,560	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,210	2,244,880	263,616	173,130	54.00
60.00	06000	LABORATORY	0	42,387	2,580,713	303,053	119,695	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	540,323	63,450	10,706	65.00
66.00	06600	PHYSICAL THERAPY	0	16,423	470,332	55,231	13,775	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,098	50,934	5,981	1,815	67.00
68.00	06800	SPEECH PATHOLOGY	0	345	8,429	990	778	68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,146	711,679	83,572	51,576	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,902,220	223,378	23,522	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	916,554	107,631	13,429	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,746	2,475,105	290,652	42,815	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,244	49,069	5,762	998	90.00
90.01	09001	SENIOR CARE	0	4,312	220,479	25,891	1,604	90.01
90.02	09002	GENERAL SURGERY	0	41,100	326,913	38,389	327	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	29,362	492,910	57,882	764	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	26,322	382,409	44,906	2,743	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	63,992	476,099	55,908	3,191	90.05
90.06	09006	OBGYN - DR SAUER	0	26,995	216,199	25,388	579	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	43,519	997,458	117,131	1,385	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	14,545	239,039	28,070	269	90.08
90.09	09009	PAIN MANAGEMENT	0	8,102	25,265	2,967	566	90.09
90.10	09010	DERMATOLOGY	0	24,146	255,483	30,001	2,252	90.10
91.00	09100	EMERGENCY	0	92,082	2,853,712	335,111	143,021	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	246,438	113,069	3,767,836	442,457	51,311	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	246,438	1,204,110	45,961,904	4,738,239	795,183	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	16,244	1,908	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	182,482	6,653,414	781,308	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	18,296	601,081	70,585	0	194.01
194.02	07952	MOB	0	0	173,322	20,353	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	246,438	1,404,888	53,405,965	5,612,393	795,183	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.03	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,466,382					5.03
7.00	00700	OPERATION OF PLANT	0	2,151,700				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,774	334,576			8.00
9.00	00900	HOUSEKEEPING	0	42,354	0	1,071,377		9.00
10.00	01000	DIETARY	0	123,241	3,734	63,189	754,487	10.00
11.00	01100	CAFETERIA	0	61,567	0	31,567	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,362	0	5,313	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	68,755	0	35,252	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,145	0	2,125	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77,130	468,093	85,682	240,004	637,758	30.00
31.00	03100	INTENSIVE CARE UNIT	13,098	62,538	46,674	32,065	116,729	31.00
43.00	04300	NURSERY	13,753	12,952	0	6,641	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	119,860	382,568	24,207	196,152	0	50.00
53.00	05300	ANESTHESIOLOGY	25,009	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	319,153	200,437	41,640	102,769	0	54.00
60.00	06000	LABORATORY	220,749	105,345	0	54,013	0	60.00
65.00	06500	RESPIRATORY THERAPY	19,745	22,926	0	11,755	0	65.00
66.00	06600	PHYSICAL THERAPY	25,405	77,563	0	39,768	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,348	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,435	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	95,119	39,375	9,087	20,189	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,380	94,034	0	48,213	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	24,767	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,962	26,466	0	13,570	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,841	16,406	417	8,412	0	90.00
90.01	09001	SENIOR CARE	2,958	0	38	0	0	90.01
90.02	09002	GENERAL SURGERY	602	0	355	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	1,408	0	13	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	5,059	0	69	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	5,885	0	148	0	0	90.05
90.06	09006	OBGYN - DR SAUER	1,067	0	752	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	2,555	0	504	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	496	0	151	0	0	90.08
90.09	09009	PAIN MANAGEMENT	1,043	0	444	0	0	90.09
90.10	09010	DERMATOLOGY	4,154	0	1,774	0	0	90.10
91.00	09100	EMERGENCY	263,769	141,590	93,341	72,597	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	94,632	0	18,851	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,466,382	1,980,491	327,881	983,594	754,487	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,594	0	9,021	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	142,821	6,695	73,228	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	10,794	0	5,534	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,466,382	2,151,700	334,576	1,071,377	754,487	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	609,424					11.00
13.00	01300	NURSING ADMINISTRATION	17,874	1,097,712				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,083	0	1,163,627			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,207	0	2,976	1,301,951		16.00
17.00	01700	SOCIAL SERVICE	6,830	0	377	0	468,058	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	140,456	527,399	34,946	68,476	323,649	30.00
31.00	03100	INTENSIVE CARE UNIT	16,528	62,060	7,171	11,628	60,901	31.00
43.00	04300	NURSERY	6,426	24,130	41	12,210	83,508	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,619	167,539	45,045	106,412	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,503	22,203	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,215	0	25,643	283,440	0	54.00
60.00	06000	LABORATORY	30,265	0	244,221	195,981	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	5,661	17,530	0	65.00
66.00	06600	PHYSICAL THERAPY	9,274	0	1,322	22,554	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,193	0	0	2,972	0	67.00
68.00	06800	SPEECH PATHOLOGY	192	0	12	1,274	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14,873	55,846	6,686	84,447	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	441,632	38,513	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	232,625	21,988	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,753	0	3,293	70,103	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	847	3,179	102	1,635	0	90.00
90.01	09001	SENIOR CARE	2,309	8,670	316	2,626	0	90.01
90.02	09002	GENERAL SURGERY	11,102	0	1,918	535	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	17,259	0	3,761	1,250	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	13,295	0	3,386	4,491	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	18,990	0	3,804	5,225	0	90.05
90.06	09006	OBGYN - DR SAUER	6,042	0	9,787	947	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	25,340	0	11,271	2,268	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	7,696	0	7,854	440	0	90.08
90.09	09009	PAIN MANAGEMENT	924	0	143	926	0	90.09
90.10	09010	DERMATOLOGY	7,157	0	3,198	3,688	0	90.10
91.00	09100	EMERGENCY	66,284	248,889	25,358	234,175	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	38,575	84,014	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	558,033	1,097,712	1,163,627	1,301,951	468,058	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,343	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	19,048	0	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	609,424	1,097,712	1,163,627	1,301,951	468,058	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	AMB DEPR					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	AMB EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE & GENERAL					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	9,076,752	0	9,076,752		30.00
31.00	03100	INTENSIVE CARE UNIT	1,223,940	0	1,223,940		31.00
43.00	04300	NURSERY	376,098	0	376,098		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,308,511	0	3,308,511		50.00
53.00	05300	ANESTHESIOLOGY	80,935	0	80,935		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,698,923	0	3,698,923		54.00
60.00	06000	LABORATORY	3,854,035	0	3,854,035		60.00
65.00	06500	RESPIRATORY THERAPY	692,096	0	692,096		65.00
66.00	06600	PHYSICAL THERAPY	715,224	0	715,224		66.00
67.00	06700	OCCUPATIONAL THERAPY	66,243	0	66,243		67.00
68.00	06800	SPEECH PATHOLOGY	13,110	0	13,110		68.00
69.00	06900	ELECTROCARDIOLOGY	1,172,449	0	1,172,449		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,814,892	0	2,814,892		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,316,994	0	1,316,994		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,007,719	0	3,007,719		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	88,668	0	88,668		90.00
90.01	09001	SENIOR CARE	264,891	0	264,891		90.01
90.02	09002	GENERAL SURGERY	380,141	0	380,141		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	575,247	0	575,247		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	456,358	0	456,358		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	569,250	0	569,250		90.05
90.06	09006	OBGYN - DR SAUER	260,761	0	260,761		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1,157,912	0	1,157,912		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	284,015	0	284,015		90.08
90.09	09009	PAIN MANAGEMENT	32,278	0	32,278		90.09
90.10	09010	DERMATOLOGY	307,707	0	307,707		90.10
91.00	09100	EMERGENCY	4,477,847	0	4,477,847		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	4,497,676	0	4,497,676		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,770,672	0	44,770,672		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	44,767	0	44,767		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,689,809	0	7,689,809		192.00
194.00	07950	MARKETING	0	0	0		194.00
194.01	07951	PHYSICIAN BILLING	707,042	0	707,042		194.01
194.02	07952	MOB	193,675	0	193,675		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	53,405,965	0	53,405,965		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,515	0	0	1,472	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	252,861	3,731	0	147,973	5.01
5.02	00570	ADMITTING	0	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	197,249	0	0	115,429	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,517	0	0	6,740	8.00
9.00	00900	HOUSEKEEPING	0	24,669	0	0	14,436	9.00
10.00	01000	DIETARY	0	71,781	0	0	42,006	10.00
11.00	01100	CAFETERIA	0	35,859	0	0	20,984	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,035	0	0	3,532	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,046	0	0	23,435	16.00
17.00	01700	SOCIAL SERVICE	0	2,414	0	0	1,413	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	272,636	0	0	159,541	30.00
31.00	03100	INTENSIVE CARE UNIT	0	36,425	0	0	21,316	31.00
43.00	04300	NURSERY	0	7,544	0	0	4,415	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	222,824	0	0	130,395	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	116,743	0	0	68,317	54.00
60.00	06000	LABORATORY	0	61,358	5,824	0	35,906	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,353	0	0	7,814	65.00
66.00	06600	PHYSICAL THERAPY	0	45,176	0	0	26,437	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	22,934	0	0	13,421	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	54,769	0	0	32,051	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,415	0	0	9,021	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	9,556	0	0	5,592	90.00
90.01	09001	SENIOR CARE	0	0	10,849	0	0	90.01
90.02	09002	GENERAL SURGERY	0	0	14,466	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	0	65,477	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	0	78,001	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	0	100,176	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0	0	30,055	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	0	56,893	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	0	33,671	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0	0	22,841	0	0	90.09
90.10	09010	DERMATOLOGY	0	0	25,087	0	0	90.10
91.00	09100	EMERGENCY	0	82,468	0	0	48,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	58,866	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,606,147	447,071	58,866	939,906	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,247	0	0	5,997	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	83,185	0	0	48,679	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	6,287	0	0	3,679	194.01
194.02	07952	MOB	0	0	173,322	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers			0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,705,866	620,393	58,866	998,261	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	ADMITTING	
			2.01	2A	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,987	3,987			4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	404,565	242	404,807		5.01
5.02	00570	ADMITTING	0	0	74	6,027	6,101	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	57	11,115	0	5.03
7.00	00700	OPERATION OF PLANT	0	312,678	38	16,310	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,257	3	2,386	0	8.00
9.00	00900	HOUSEKEEPING	0	39,105	76	7,800	0	9.00
10.00	01000	DIETARY	0	113,787	28	4,278	0	10.00
11.00	01100	CAFETERIA	0	56,843	38	3,913	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,567	100	8,066	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	31	8,729	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63,481	93	8,836	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,827	43	3,446	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	432,177	525	48,749	324	30.00
31.00	03100	INTENSIVE CARE UNIT	0	57,741	69	5,969	55	31.00
43.00	04300	NURSERY	0	11,959	24	1,584	58	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	353,219	145	16,351	503	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	134	105	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	185,060	154	19,014	1,285	54.00
60.00	06000	LABORATORY	0	103,088	120	21,859	927	60.00
65.00	06500	RESPIRATORY THERAPY	0	21,167	0	4,577	83	65.00
66.00	06600	PHYSICAL THERAPY	0	71,613	47	3,984	107	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	6	431	14	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1	71	6	68.00
69.00	06900	ELECTROCARDIOLOGY	0	36,355	68	6,028	399	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	86,820	0	16,112	182	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	7,763	104	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,436	50	20,964	332	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	15,148	4	416	8	90.00
90.01	09001	SENIOR CARE	0	10,849	12	1,867	12	90.01
90.02	09002	GENERAL SURGERY	0	14,466	117	2,769	3	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	65,477	83	4,175	6	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	78,001	75	3,239	21	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	100,176	181	4,033	25	90.05
90.06	09006	OBGYN - DR SAUER	0	30,055	77	1,831	4	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	56,893	123	8,448	11	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	33,671	41	2,025	2	90.08
90.09	09009	PAIN MANAGEMENT	0	22,841	23	214	4	90.09
90.10	09010	DERMATOLOGY	0	25,087	68	2,164	17	90.10
91.00	09100	EMERGENCY	0	130,728	261	24,171	1,107	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	246,438	305,304	321	31,914	397	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	246,438	3,298,428	3,418	341,762	6,101	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,244	0	138	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	131,864	517	56,348	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	9,966	52	5,091	0	194.01
194.02	07952	MOB	0	173,322	0	1,468	0	194.02
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	246,438	3,629,824	3,987	404,807	6,101	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.03	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	11,172					5.03
7.00	00700	OPERATION OF PLANT	0	329,026				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,024	23,670			8.00
9.00	00900	HOUSEKEEPING	0	6,477	0	53,458		9.00
10.00	01000	DIETARY	0	18,845	264	3,153	140,355	10.00
11.00	01100	CAFETERIA	0	9,414	0	1,575	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,584	0	265	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,514	0	1,759	0	16.00
17.00	01700	SOCIAL SERVICE	0	634	0	106	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	585	71,579	6,062	11,976	118,640	30.00
31.00	03100	INTENSIVE CARE UNIT	99	9,563	3,302	1,600	21,715	31.00
43.00	04300	NURSERY	104	1,981	0	331	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	909	58,500	1,713	9,787	0	50.00
53.00	05300	ANESTHESIOLOGY	190	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,473	30,650	2,946	5,128	0	54.00
60.00	06000	LABORATORY	1,674	16,109	0	2,695	0	60.00
65.00	06500	RESPIRATORY THERAPY	150	3,506	0	587	0	65.00
66.00	06600	PHYSICAL THERAPY	193	11,860	0	1,984	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	11	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	721	6,021	643	1,007	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	329	14,379	0	2,406	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	188	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	599	4,047	0	677	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14	2,509	30	420	0	90.00
90.01	09001	SENIOR CARE	22	0	3	0	0	90.01
90.02	09002	GENERAL SURGERY	5	0	25	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	11	0	1	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	38	0	5	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	45	0	10	0	0	90.05
90.06	09006	OBGYN - DR SAUER	8	0	53	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	19	0	36	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	4	0	11	0	0	90.08
90.09	09009	PAIN MANAGEMENT	8	0	31	0	0	90.09
90.10	09010	DERMATOLOGY	31	0	126	0	0	90.10
91.00	09100	EMERGENCY	2,000	21,651	6,601	3,622	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	717	0	1,334	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,172	302,847	23,196	49,078	140,355	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,690	0	450	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	21,839	474	3,654	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	1,650	0	276	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,172	329,026	23,670	53,458	140,355	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	71,783					11.00
13.00	01300	NURSING ADMINISTRATION	2,105	21,687				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,423	0	10,183			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,440	0	26	88,149		16.00
17.00	01700	SOCIAL SERVICE	805	0	3	0	8,864	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,541	10,420	306	4,633	6,130	30.00
31.00	03100	INTENSIVE CARE UNIT	1,947	1,226	63	787	1,153	31.00
43.00	04300	NURSERY	757	477	0	826	1,581	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,256	3,310	394	7,199	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	22	1,502	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,208	0	224	19,241	0	54.00
60.00	06000	LABORATORY	3,565	0	2,137	13,259	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	50	1,186	0	65.00
66.00	06600	PHYSICAL THERAPY	1,092	0	12	1,526	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	141	0	0	201	0	67.00
68.00	06800	SPEECH PATHOLOGY	23	0	0	86	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,752	1,103	59	5,713	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,862	2,606	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	2,036	1,488	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	795	0	29	4,743	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	100	63	1	111	0	90.00
90.01	09001	SENIOR CARE	272	171	3	178	0	90.01
90.02	09002	GENERAL SURGERY	1,308	0	17	36	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	2,033	0	33	85	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	1,566	0	30	304	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	2,237	0	33	353	0	90.05
90.06	09006	OBGYN - DR SAUER	712	0	86	64	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	2,985	0	99	153	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	907	0	69	30	0	90.08
90.09	09009	PAIN MANAGEMENT	109	0	1	63	0	90.09
90.10	09010	DERMATOLOGY	843	0	28	249	0	90.10
91.00	09100	EMERGENCY	7,807	4,917	222	15,843	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	338	5,684	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,729	21,687	10,183	88,149	8,864	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,810	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	2,244	0	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	71,783	21,687	10,183	88,149	8,864	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	AMB DEPR					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	AMB EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE & GENERAL					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	728,647	0	728,647		30.00
31.00	03100	INTENSIVE CARE UNIT	105,289	0	105,289		31.00
43.00	04300	NURSERY	19,682	0	19,682		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	457,286	0	457,286		50.00
53.00	05300	ANESTHESIOLOGY	1,953	0	1,953		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	271,383	0	271,383		54.00
60.00	06000	LABORATORY	165,433	0	165,433		60.00
65.00	06500	RESPIRATORY THERAPY	31,306	0	31,306		65.00
66.00	06600	PHYSICAL THERAPY	92,418	0	92,418		66.00
67.00	06700	OCCUPATIONAL THERAPY	818	0	818		67.00
68.00	06800	SPEECH PATHOLOGY	198	0	198		68.00
69.00	06900	ELECTROCARDIOLOGY	59,869	0	59,869		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,696	0	126,696		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,579	0	11,579		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,672	0	56,672		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	18,824	0	18,824		90.00
90.01	09001	SENIOR CARE	13,389	0	13,389		90.01
90.02	09002	GENERAL SURGERY	18,746	0	18,746		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	71,904	0	71,904		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	83,279	0	83,279		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	107,093	0	107,093		90.05
90.06	09006	OBGYN - DR SAUER	32,890	0	32,890		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	68,767	0	68,767		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	36,760	0	36,760		90.08
90.09	09009	PAIN MANAGEMENT	23,294	0	23,294		90.09
90.10	09010	DERMATOLOGY	28,613	0	28,613		90.10
91.00	09100	EMERGENCY	218,930	0	218,930		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	346,009	0	346,009		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,197,727	0	3,197,727		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,522	0	19,522		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	218,506	0	218,506		192.00
194.00	07950	MARKETING	0	0	0		194.00
194.01	07951	PHYSICIAN BILLING	19,279	0	19,279		194.01
194.02	07952	MOB	174,790	0	174,790		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,629,824	0	3,629,824		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	
			1.00	1.01	1.02	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	135,674					1.00
1.01	00101	MOB	0	32,594				1.01
1.02	00102	AMB DEPR	0	0	11,032			1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				135,674		2.00
2.01	00201	AMB EQUIP				0	11,032	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	200	0	0	200	0	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	20,111	196	0	20,111	0	5.01
5.02	00570	ADMITTING	0	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	15,688	0	0	15,688	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	916	0	0	916	0	8.00
9.00	00900	HOUSEKEEPING	1,962	0	0	1,962	0	9.00
10.00	01000	DIETARY	5,709	0	0	5,709	0	10.00
11.00	01100	CAFETERIA	2,852	0	0	2,852	0	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0	16.00
17.00	01700	SOCIAL SERVICE	192	0	0	192	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,684	0	0	21,684	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	0	0	2,897	0	31.00
43.00	04300	NURSERY	600	0	0	600	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	0	0	17,722	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	0	0	9,285	0	54.00
60.00	06000	LABORATORY	4,880	306	0	4,880	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	0	1,062	0	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	0	3,593	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	0	0	1,824	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	0	1,226	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	760	0	0	760	0	90.00
90.01	09001	SENIOR CARE	0	570	0	0	0	90.01
90.02	09002	GENERAL SURGERY	0	760	0	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	3,440	0	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	4,098	0	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	5,263	0	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0	1,579	0	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	2,989	0	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	1,769	0	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0	1,200	0	0	0	90.09
90.10	09010	DERMATOLOGY	0	1,318	0	0	0	90.10
91.00	09100	EMERGENCY	6,559	0	0	6,559	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	11,032	0	11,032	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,743	23,488	11,032	127,743	11,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,616	0	0	6,616	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	0	500	0	194.01
194.02	07952	MOB	0	9,106	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,705,866	620,393	58,866	998,261	246,438	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.573271	19.033963	5.335932	7.357791	22.338470	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	
			1.00	1.01	1.02	2.00	2.01	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			4.00	5A.01	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	27,654,641					4.00
5.01	00590	ADMINISTRATIVE & GENERAL	1,681,232	-5,612,393	47,793,572			5.01
5.02	00570	ADMITTING	516,455	0	711,618	171,028,988		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	395,285	0	1,312,281	0	171,028,988	5.03
7.00	00700	OPERATION OF PLANT	264,804	0	1,925,579	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,289	0	281,720	0	0	8.00
9.00	00900	HOUSEKEEPING	529,169	0	920,884	0	0	9.00
10.00	01000	DIETARY	193,845	0	505,019	0	0	10.00
11.00	01100	CAFETERIA	262,369	0	462,033	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	691,198	0	952,331	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	218,416	0	1,030,529	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	645,573	0	1,043,252	0	0	16.00
17.00	01700	SOCIAL SERVICE	299,647	0	406,809	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,611,496	0	5,755,472	8,995,848	8,995,848	30.00
31.00	03100	INTENSIVE CARE UNIT	477,684	0	704,694	1,527,626	1,527,626	31.00
43.00	04300	NURSERY	166,443	0	187,018	1,603,986	1,603,986	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,006,361	0	1,930,428	13,979,477	13,979,477	50.00
53.00	05300	ANESTHESIOLOGY	0	0	15,804	2,916,787	2,916,787	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,067,108	0	2,244,880	37,225,668	37,225,668	54.00
60.00	06000	LABORATORY	834,370	0	2,580,713	25,746,371	25,746,371	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	540,323	2,302,938	2,302,938	65.00
66.00	06600	PHYSICAL THERAPY	323,275	0	470,332	2,962,985	2,962,985	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,296	0	50,934	390,488	390,488	67.00
68.00	06800	SPEECH PATHOLOGY	6,796	0	8,429	167,360	167,360	68.00
69.00	06900	ELECTROCARDIOLOGY	475,303	0	711,679	11,093,941	11,093,941	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,902,220	5,059,510	5,059,510	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	916,554	2,888,603	2,888,603	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	349,315	0	2,475,105	9,209,486	9,209,486	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	24,483	0	49,069	214,760	214,760	90.00
90.01	09001	SENIOR CARE	84,871	0	220,479	344,980	344,980	90.01
90.02	09002	GENERAL SURGERY	809,036	0	326,913	70,234	70,234	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	577,979	0	492,910	164,263	164,263	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	518,135	0	382,409	589,989	589,989	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	1,259,659	0	476,099	686,388	686,388	90.05
90.06	09006	OBGYN - DR SAUER	531,396	0	216,199	124,454	124,454	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	856,664	0	997,458	297,959	297,959	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	286,311	0	239,039	57,839	57,839	90.08
90.09	09009	PAIN MANAGEMENT	159,479	0	25,265	121,661	121,661	90.09
90.10	09010	DERMATOLOGY	475,298	0	255,483	484,459	484,459	90.10
91.00	09100	EMERGENCY	1,812,611	0	2,853,712	30,763,872	30,763,872	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,225,732	0	3,767,836	11,037,056	11,037,056	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,702,383	-5,612,393	40,349,511	171,028,988	171,028,988	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	16,244	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,592,102	0	6,653,414	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	360,156	0	601,081	0	0	194.01
194.02	07952	MOB	0	0	173,322	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,404,888		5,612,393	795,183	1,466,382	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.050801		0.117430	0.004649	0.008574	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,987		404,807	6,101	11,172	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000144		0.008470	0.000036	0.000065	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			4.00	5A.01	5.01	5.02	5.03	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT	99,675					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	916	203,645				8.00
9.00	00900	HOUSEKEEPING	1,962	0	96,797			9.00
10.00	01000	DIETARY	5,709	2,273	5,709	3,639		10.00
11.00	01100	CAFETERIA	2,852	0	2,852	0	31,674	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	480	0	929	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	628	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	3,185	0	1,518	16.00
17.00	01700	SOCIAL SERVICE	192	0	192	0	355	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,684	52,152	21,684	3,076	7,300	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	28,409	2,897	563	859	31.00
43.00	04300	NURSERY	600	0	600	0	334	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	14,734	17,722	0	2,319	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	25,345	9,285	0	2,298	54.00
60.00	06000	LABORATORY	4,880	0	4,880	0	1,573	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	1,062	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	3,593	0	482	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	62	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	10	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	5,531	1,824	0	773	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	4,356	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	1,226	0	351	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	760	254	760	0	44	90.00
90.01	09001	SENIOR CARE	0	23	0	0	120	90.01
90.02	09002	GENERAL SURGERY	0	216	0	0	577	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	8	0	0	897	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	42	0	0	691	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	90	0	0	987	90.05
90.06	09006	OBGYN - DR SAUER	0	458	0	0	314	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	307	0	0	1,317	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	92	0	0	400	90.08
90.09	09009	PAIN MANAGEMENT	0	270	0	0	48	90.09
90.10	09010	DERMATOLOGY	0	1,080	0	0	372	90.10
91.00	09100	EMERGENCY	6,559	56,812	6,559	0	3,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	11,474	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	91,744	199,570	88,866	3,639	29,003	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	815	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,616	4,075	6,616	0	1,681	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	500	0	990	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,151,700	334,576	1,071,377	754,487	609,424	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.587158	1.642937	11.068287	207.333608	19.240513	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	329,026	23,670	53,458	140,355	71,783	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.300988	0.116232	0.552269	38.569662	2.266307	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			13.00	14.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	15,194					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,584,743				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,724	171,028,988			16.00
17.00	01700	SOCIAL SERVICE	0	1,487	0	4,327		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,300	137,689	8,995,848	2,992		30.00
31.00	03100	INTENSIVE CARE UNIT	859	28,255	1,527,626	563		31.00
43.00	04300	NURSERY	334	161	1,603,986	772		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,319	177,479	13,979,477	0		50.00
53.00	05300	ANESTHESIOLOGY	0	9,862	2,916,787	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	101,033	37,225,668	0		54.00
60.00	06000	LABORATORY	0	962,241	25,746,371	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	22,306	2,302,938	0		65.00
66.00	06600	PHYSICAL THERAPY	0	5,210	2,962,985	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	390,488	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	46	167,360	0		68.00
69.00	06900	ELECTROCARDIOLOGY	773	26,345	11,093,941	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,740,048	5,059,510	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	916,554	2,888,603	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,973	9,209,486	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	44	402	214,760	0		90.00
90.01	09001	SENIOR CARE	120	1,244	344,980	0		90.01
90.02	09002	GENERAL SURGERY	0	7,557	70,234	0		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	14,818	164,263	0		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	13,342	589,989	0		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	14,988	686,388	0		90.05
90.06	09006	OBGYN - DR SAUER	0	38,562	124,454	0		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	44,408	297,959	0		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	30,944	57,839	0		90.08
90.09	09009	PAIN MANAGEMENT	0	563	121,661	0		90.09
90.10	09010	DERMATOLOGY	0	12,602	484,459	0		90.10
91.00	09100	EMERGENCY	3,445	99,913	30,763,872	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	151,987	11,037,056	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,194	4,584,743	171,028,988	4,327		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	MARKETING	0	0	0	0		194.00
194.01	07951	PHYSICIAN BILLING	0	0	0	0		194.01
194.02	07952	MOB	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,097,712	1,163,627	1,301,951	468,058		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	72.246413	0.253804	0.007612	108.171481		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	21,687	10,183	88,149	8,864		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.427340	0.002221	0.000515	2.048532		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 11:29 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			13.00	14.00	16.00	17.00		
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,076,752		9,076,752	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,223,940		1,223,940	0	0	31.00
43.00	04300	NURSERY	376,098		376,098	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,308,511		3,308,511	0	0	50.00
53.00	05300	ANESTHESIOLOGY	80,935		80,935	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,698,923		3,698,923	0	0	54.00
60.00	06000	LABORATORY	3,854,035		3,854,035	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	692,096	0	692,096	0	0	65.00
66.00	06600	PHYSICAL THERAPY	715,224	0	715,224	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	66,243	0	66,243	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,110	0	13,110	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,172,449		1,172,449	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,814,892		2,814,892	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,316,994		1,316,994	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,007,719		3,007,719	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	88,668		88,668	0	0	90.00
90.01	09001	SENIOR CARE	264,891		264,891	0	0	90.01
90.02	09002	GENERAL SURGERY	380,141		380,141	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	575,247		575,247	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	456,358		456,358	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	569,250		569,250	0	0	90.05
90.06	09006	OBGYN - DR SAUER	260,761		260,761	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1,157,912		1,157,912	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	284,015		284,015	0	0	90.08
90.09	09009	PAIN MANAGEMENT	32,278		32,278	0	0	90.09
90.10	09010	DERMATOLOGY	307,707		307,707	0	0	90.10
91.00	09100	EMERGENCY	4,477,847		4,477,847	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,136,631		2,136,631		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,497,676		4,497,676	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	46,907,303	0	46,907,303	0	0	200.00
201.00		Less Observation Beds	2,136,631		2,136,631		0	201.00
202.00		Total (see instructions)	44,770,672	0	44,770,672	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,023,588		7,023,588			30.00
31.00	03100	INTENSIVE CARE UNIT	1,527,626		1,527,626			31.00
43.00	04300	NURSERY	1,603,986		1,603,986			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,710,785	11,268,692	13,979,477	0.236669	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	900,124	2,016,663	2,916,787	0.027748	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	976,030	36,249,638	37,225,668	0.099365	0.000000	54.00
60.00	06000	LABORATORY	3,416,735	22,329,636	25,746,371	0.149692	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,593,109	709,829	2,302,938	0.300527	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	419,494	2,543,491	2,962,985	0.241386	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	206,599	183,889	390,488	0.169642	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	69,040	98,320	167,360	0.078334	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	518,710	10,575,231	11,093,941	0.105684	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,543,363	3,516,147	5,059,510	0.556357	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	919,375	1,969,228	2,888,603	0.455928	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,661,279	6,548,207	9,209,486	0.326589	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	121	214,639	214,760	0.412870	0.000000	90.00
90.01	09001	SENIOR CARE	0	344,980	344,980	0.767845	0.000000	90.01
90.02	09002	GENERAL SURGERY	0	70,234	70,234	5.412493	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	164,263	164,263	3.501988	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	589,989	589,989	0.773503	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	24	686,364	686,388	0.829341	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	0	124,454	124,454	2.095240	0.000000	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	297,959	297,959	3.886145	0.000000	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	57,839	57,839	4.910441	0.000000	90.08
90.09	09009	PAIN MANAGEMENT	0	121,661	121,661	0.265311	0.000000	90.09
90.10	09010	DERMATOLOGY	0	484,459	484,459	0.635156	0.000000	90.10
91.00	09100	EMERGENCY	469,367	30,294,505	30,763,872	0.145555	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	13,740	1,958,520	1,972,260	1.083341	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	11,037,056	11,037,056	0.407507	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,573,095	144,455,893	171,028,988			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	26,573,095	144,455,893	171,028,988			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
90.02	09002	GENERAL SURGERY	0.000000		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.000000		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.000000		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.000000		90.05
90.06	09006	OBGYN - DR SAUER	0.000000		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0.000000		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.000000		90.08
90.09	09009	PAIN MANAGEMENT	0.000000		90.09
90.10	09010	DERMATOLOGY	0.000000		90.10
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 11:29 am

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	9,076,752		9,076,752	0	9,076,752	30.00
31.00	03100	INTENSIVE CARE UNIT	1,223,940		1,223,940	0	1,223,940	31.00
43.00	04300	NURSERY	376,098		376,098	0	376,098	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,308,511		3,308,511	0	3,308,511	50.00
53.00	05300	ANESTHESIOLOGY	80,935		80,935	0	80,935	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,698,923		3,698,923	0	3,698,923	54.00
60.00	06000	LABORATORY	3,854,035		3,854,035	0	3,854,035	60.00
65.00	06500	RESPIRATORY THERAPY	692,096	0	692,096	0	692,096	65.00
66.00	06600	PHYSICAL THERAPY	715,224	0	715,224	0	715,224	66.00
67.00	06700	OCCUPATIONAL THERAPY	66,243	0	66,243	0	66,243	67.00
68.00	06800	SPEECH PATHOLOGY	13,110	0	13,110	0	13,110	68.00
69.00	06900	ELECTROCARDIOLOGY	1,172,449		1,172,449	0	1,172,449	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,814,892		2,814,892	0	2,814,892	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,316,994		1,316,994	0	1,316,994	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,007,719		3,007,719	0	3,007,719	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	88,668		88,668	0	88,668	90.00
90.01	09001	SENIOR CARE	264,891		264,891	0	264,891	90.01
90.02	09002	GENERAL SURGERY	380,141		380,141	0	380,141	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	575,247		575,247	0	575,247	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	456,358		456,358	0	456,358	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	569,250		569,250	0	569,250	90.05
90.06	09006	OBGYN - DR SAUER	260,761		260,761	0	260,761	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1,157,912		1,157,912	0	1,157,912	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	284,015		284,015	0	284,015	90.08
90.09	09009	PAIN MANAGEMENT	32,278		32,278	0	32,278	90.09
90.10	09010	DERMATOLOGY	307,707		307,707	0	307,707	90.10
91.00	09100	EMERGENCY	4,477,847		4,477,847	0	4,477,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,136,631		2,136,631		2,136,631	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,497,676		4,497,676	0	4,497,676	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	46,907,303	0	46,907,303	0	46,907,303	200.00
201.00		Less Observation Beds	2,136,631		2,136,631		2,136,631	201.00
202.00		Total (see instructions)	44,770,672	0	44,770,672	0	44,770,672	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 11:29 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,023,588		7,023,588			30.00
31.00	03100	INTENSIVE CARE UNIT	1,527,626		1,527,626			31.00
43.00	04300	NURSERY	1,603,986		1,603,986			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,710,785	11,268,692	13,979,477	0.236669	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	900,124	2,016,663	2,916,787	0.027748	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	976,030	36,249,638	37,225,668	0.099365	0.000000	54.00
60.00	06000	LABORATORY	3,416,735	22,329,636	25,746,371	0.149692	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,593,109	709,829	2,302,938	0.300527	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	419,494	2,543,491	2,962,985	0.241386	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	206,599	183,889	390,488	0.169642	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	69,040	98,320	167,360	0.078334	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	518,710	10,575,231	11,093,941	0.105684	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,543,363	3,516,147	5,059,510	0.556357	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	919,375	1,969,228	2,888,603	0.455928	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,661,279	6,548,207	9,209,486	0.326589	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	121	214,639	214,760	0.412870	0.000000	90.00
90.01	09001	SENIOR CARE	0	344,980	344,980	0.767845	0.000000	90.01
90.02	09002	GENERAL SURGERY	0	70,234	70,234	5.412493	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	164,263	164,263	3.501988	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	589,989	589,989	0.773503	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	24	686,364	686,388	0.829341	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	0	124,454	124,454	2.095240	0.000000	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	297,959	297,959	3.886145	0.000000	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	57,839	57,839	4.910441	0.000000	90.08
90.09	09009	PAIN MANAGEMENT	0	121,661	121,661	0.265311	0.000000	90.09
90.10	09010	DERMATOLOGY	0	484,459	484,459	0.635156	0.000000	90.10
91.00	09100	EMERGENCY	469,367	30,294,505	30,763,872	0.145555	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	13,740	1,958,520	1,972,260	1.083341	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	11,037,056	11,037,056	0.407507	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,573,095	144,455,893	171,028,988			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	26,573,095	144,455,893	171,028,988			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 11:29 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
90.02	09002	GENERAL SURGERY	0.000000		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.000000		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.000000		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.000000		90.05
90.06	09006	OBGYN - DR SAUER	0.000000		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0.000000		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.000000		90.08
90.09	09009	PAIN MANAGEMENT	0.000000		90.09
90.10	09010	DERMATOLOGY	0.000000		90.10
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	457,286	13,979,477	0.032711	265,461	8,683	50.00
53.00	05300	ANESTHESIOLOGY	1,953	2,916,787	0.000670	44,375	30	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	271,383	37,225,668	0.007290	254,161	1,853	54.00
60.00	06000	LABORATORY	165,433	25,746,371	0.006425	896,465	5,760	60.00
65.00	06500	RESPIRATORY THERAPY	31,306	2,302,938	0.013594	648,255	8,812	65.00
66.00	06600	PHYSICAL THERAPY	92,418	2,962,985	0.031191	166,336	5,188	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	390,488	0.002095	80,056	168	67.00
68.00	06800	SPEECH PATHOLOGY	198	167,360	0.001183	6,272	7	68.00
69.00	06900	ELECTROCARDIOLOGY	59,869	11,093,941	0.005397	244,585	1,320	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,696	5,059,510	0.025041	542,166	13,576	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,579	2,888,603	0.004009	201,646	808	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,672	9,209,486	0.006154	819,402	5,043	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	18,824	214,760	0.087651	121	11	90.00
90.01	09001	SENIOR CARE	13,389	344,980	0.038811	0	0	90.01
90.02	09002	GENERAL SURGERY	18,746	70,234	0.266908	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	71,904	164,263	0.437737	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	83,279	589,989	0.141153	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	107,093	686,388	0.156024	24	4	90.05
90.06	09006	OBGYN - DR SAUER	32,890	124,454	0.264274	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	68,767	297,959	0.230793	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	36,760	57,839	0.635557	0	0	90.08
90.09	09009	PAIN MANAGEMENT	23,294	121,661	0.191466	0	0	90.09
90.10	09010	DERMATOLOGY	28,613	484,459	0.059062	0	0	90.10
91.00	09100	EMERGENCY	218,930	30,763,872	0.007116	12,448	89	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	171,520	1,972,260	0.086966	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,169,620	149,836,732		4,181,773	51,352	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Hospital | Cost

		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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
90.02	09002	GENERAL SURGERY	0	0	0	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	0	0	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	0	0	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0	0	0	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	0	0	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	0	0	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0	0	0	0	0	90.09
90.10	09010	DERMATOLOGY	0	0	0	0	0	90.10
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	13,979,477	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,916,787	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	37,225,668	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	25,746,371	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,302,938	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,962,985	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	390,488	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	167,360	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	11,093,941	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,059,510	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,888,603	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,209,486	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	214,760	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	344,980	0.000000	90.01
90.02	09002	GENERAL SURGERY	0	0	0	70,234	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	0	0	164,263	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	0	0	589,989	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	686,388	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	0	0	0	124,454	0.000000	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	0	0	297,959	0.000000	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	0	0	57,839	0.000000	90.08
90.09	09009	PAIN MANAGEMENT	0	0	0	121,661	0.000000	90.09
90.10	09010	DERMATOLOGY	0	0	0	484,459	0.000000	90.10
91.00	09100	EMERGENCY	0	0	0	30,763,872	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,972,260	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	149,836,732		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	265,461	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	44,375	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	254,161	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	896,465	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	648,255	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	166,336	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	80,056	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,272	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	244,585	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	542,166	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	201,646	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	819,402	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	121	0	0	0	90.00
90.01	09001	SENIOR CARE	0.000000	0	0	0	0	90.01
90.02	09002	GENERAL SURGERY	0.000000	0	0	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.000000	0	0	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.000000	0	0	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.000000	24	0	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0.000000	0	0	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0.000000	0	0	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.000000	0	0	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.000000	0	0	0	0	90.09
90.10	09010	DERMATOLOGY	0.000000	0	0	0	0	90.10
91.00	09100	EMERGENCY	0.000000	12,448	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,181,773	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.236669	0	2,166,613	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.027748	0	386,945	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099365	0	9,548,925	0	0	54.00
60.00	06000	LABORATORY	0.149692	0	5,598,364	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.300527	0	317,384	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.241386	0	551,494	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.169642	0	64,246	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.078334	0	25,863	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.105684	0	3,351,033	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556357	0	528,371	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.455928	0	630,740	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326589	0	3,553,540	40,530	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.412870	0	43,200	0	0	90.00
90.01	09001	SENIOR CARE	0.767845	0	252,266	0	0	90.01
90.02	09002	GENERAL SURGERY	5.412493	0	10,677	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	3.501988	0	3,936	1,312	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.773503	0	162,900	942	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.829341	0	29,341	0	0	90.05
90.06	09006	OBGYN - DR SAUER	2.095240	0	6,007	1,521	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	3.886145	0	7,287	5,317	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	4.910441	0	9,861	1,523	0	90.08
90.09	09009	PAIN MANAGEMENT	0.265311	0	1,860	0	0	90.09
90.10	09010	DERMATOLOGY	0.635156	0	6,504	0	0	90.10
91.00	09100	EMERGENCY	0.145555	0	6,596,143	36,847	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.083341	0	701,785	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.407507		0			95.00
200.00		Subtotal (see instructions)		0	34,555,285	87,992	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	34,555,285	87,992	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	512,770	0		50.00
53.00	05300	ANESTHESIOLOGY	10,737	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	948,829	0		54.00
60.00	06000	LABORATORY	838,030	0		60.00
65.00	06500	RESPIRATORY THERAPY	95,382	0		65.00
66.00	06600	PHYSICAL THERAPY	133,123	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	10,899	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,026	0		68.00
69.00	06900	ELECTROCARDIOLOGY	354,151	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	293,963	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	287,572	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,160,547	13,237		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	17,836	0		90.00
90.01	09001	SENIOR CARE	193,701	0		90.01
90.02	09002	GENERAL SURGERY	57,789	0		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	13,784	4,595		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	126,004	729		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	24,334	0		90.05
90.06	09006	OBGYN - DR SAUER	12,586	3,187		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	28,318	20,663		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	48,422	7,479		90.08
90.09	09009	PAIN MANAGEMENT	493	0		90.09
90.10	09010	DERMATOLOGY	4,131	0		90.10
91.00	09100	EMERGENCY	960,102	5,363		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	760,272	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	6,895,801	55,253		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,895,801	55,253		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/31/2022 11:29 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.236669	0	88,615	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.027748	0	128,064	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099365	0	657,827	0	0	54.00
60.00	06000	LABORATORY	0.149692	0	385,518	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.300527	0	11,093	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.241386	0	6,417	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.169642	0	3,599	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.078334	0	3,107	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.105684	0	96,610	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556357	0	22,231	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.455928	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326589	0	41,017	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.412870	0	752	0	0	90.00
90.01	09001	SENIOR CARE	0.767845	0	0	0	0	90.01
90.02	09002	GENERAL SURGERY	5.412493	0	913	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	3.501988	0	16,750	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.773503	0	7,387	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.829341	0	24,177	0	0	90.05
90.06	09006	OBGYN - DR SAUER	2.095240	0	53,808	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	3.886145	0	9,191	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	4.910441	0	4,986	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.265311	0	0	0	0	90.09
90.10	09010	DERMATOLOGY	0.635156	0	2,741	0	0	90.10
91.00	09100	EMERGENCY	0.145555	0	704,089	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.083341	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.407507	0	337,326			95.00
200.00		Subtotal (see instructions)		0	2,606,218	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	2,606,218	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/31/2022 11:29 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	20,972	0		50.00
53.00	05300	ANESTHESIOLOGY	3,554	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,365	0		54.00
60.00	06000	LABORATORY	57,709	0		60.00
65.00	06500	RESPIRATORY THERAPY	3,334	0		65.00
66.00	06600	PHYSICAL THERAPY	1,549	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	611	0		67.00
68.00	06800	SPEECH PATHOLOGY	243	0		68.00
69.00	06900	ELECTROCARDIOLOGY	10,210	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,368	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,396	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	310	0		90.00
90.01	09001	SENIOR CARE	0	0		90.01
90.02	09002	GENERAL SURGERY	4,942	0		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	58,658	0		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	5,714	0		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	20,051	0		90.05
90.06	09006	OBGYN - DR SAUER	112,741	0		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	35,718	0		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	24,483	0		90.08
90.09	09009	PAIN MANAGEMENT	0	0		90.09
90.10	09010	DERMATOLOGY	1,741	0		90.10
91.00	09100	EMERGENCY	102,484	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	137,463			95.00
200.00		Subtotal (see instructions)	693,616	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	693,616	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | 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)	4,023	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,939	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)	2,992	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	84	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)	858	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)	84	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,076,752	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)	189,522	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,887,230	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)	8,887,230	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,256.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,935,828	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)	1,935,828	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,223,940	563	2,173.96	216	469,575	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,161,460	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,566,863	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)	189,522	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)	189,522	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)	947	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,256.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,136,631	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	728,647	9,076,752	0.080276	2,136,631	171,520	90.00
91.00	Nursing Program cost	0	9,076,752	0.000000	2,136,631	0	91.00
92.00	Allied health cost	0	9,076,752	0.000000	2,136,631	0	92.00
93.00	All other Medical Education	0	9,076,752	0.000000	2,136,631	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 11:29 am

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)	4,023	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,939	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)	2,992	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	84	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)	64	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)	772	15.00
16.00	Nursery days (title V or XIX only)	37	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,076,752	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)	189,522	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,887,230	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)	8,887,230	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,256.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	144,397	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)	144,397	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 11:29 am

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)	376,098	772	487.17	37	18,025	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,223,940	563	2,173.96	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)	71,127	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	233,549	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)	947	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,256.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,136,631	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 11:29 am

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	728,647	9,076,752	0.080276	2,136,631	171,520	90.00
91.00	Nursing Program cost	0	9,076,752	0.000000	2,136,631	0	91.00
92.00	Allied health cost	0	9,076,752	0.000000	2,136,631	0	92.00
93.00	All other Medical Education	0	9,076,752	0.000000	2,136,631	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,184,412		30.00
31.00	03100	INTENSIVE CARE UNIT		579,056		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.236669	265,461	62,826	50.00
53.00	05300	ANESTHESIOLOGY	0.027748	44,375	1,231	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099365	254,161	25,255	54.00
60.00	06000	LABORATORY	0.149692	896,465	134,194	60.00
65.00	06500	RESPIRATORY THERAPY	0.300527	648,255	194,818	65.00
66.00	06600	PHYSICAL THERAPY	0.241386	166,336	40,151	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.169642	80,056	13,581	67.00
68.00	06800	SPEECH PATHOLOGY	0.078334	6,272	491	68.00
69.00	06900	ELECTROCARDIOLOGY	0.105684	244,585	25,849	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556357	542,166	301,638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.455928	201,646	91,936	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326589	819,402	267,608	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.412870	121	50	90.00
90.01	09001	SENIOR CARE	0.767845	0	0	90.01
90.02	09002	GENERAL SURGERY	5.412493	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	3.501988	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.773503	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.829341	24	20	90.05
90.06	09006	OBGYN - DR SAUER	2.095240	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	3.886145	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	4.910441	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.265311	0	0	90.09
90.10	09010	DERMATOLOGY	0.635156	0	0	90.10
91.00	09100	EMERGENCY	0.145555	12,448	1,812	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.083341	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,181,773	1,161,460	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,181,773		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.236669	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.027748	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099365	2,262	225	54.00
60.00	06000	LABORATORY	0.149692	11,632	1,741	60.00
65.00	06500	RESPIRATORY THERAPY	0.300527	19,445	5,844	65.00
66.00	06600	PHYSICAL THERAPY	0.241386	36,960	8,922	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.169642	28,651	4,860	67.00
68.00	06800	SPEECH PATHOLOGY	0.078334	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.105684	422	45	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556357	20,494	11,402	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.455928	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326589	14,809	4,836	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.412870	0	0	90.00
90.01	09001	SENIOR CARE	0.767845	0	0	90.01
90.02	09002	GENERAL SURGERY	5.412493	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	3.501988	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.773503	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.829341	0	0	90.05
90.06	09006	OBGYN - DR SAUER	2.095240	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	3.886145	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	4.910441	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.265311	0	0	90.09
90.10	09010	DERMATOLOGY	0.635156	0	0	90.10
91.00	09100	EMERGENCY	0.145555	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.083341	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		134,675	37,875	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)		134,675		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/31/2022 11:29 am

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		332,486		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		115,279		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.236669	34,368	8,134	50.00
53.00	05300	ANESTHESIOLOGY	0.027748	13,900	386	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099365	17,187	1,708	54.00
60.00	06000	LABORATORY	0.149692	99,719	14,927	60.00
65.00	06500	RESPIRATORY THERAPY	0.300527	67,615	20,320	65.00
66.00	06600	PHYSICAL THERAPY	0.241386	6,975	1,684	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.169642	4,385	744	67.00
68.00	06800	SPEECH PATHOLOGY	0.078334	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.105684	6,712	709	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556357	10,589	5,891	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.455928	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326589	48,152	15,726	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.412870	0	0	90.00
90.01	09001	SENIOR CARE	0.767845	0	0	90.01
90.02	09002	GENERAL SURGERY	5.412493	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	3.501988	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.773503	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.829341	0	0	90.05
90.06	09006	OBGYN - DR SAUER	2.095240	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	3.886145	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	4.910441	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.265311	0	0	90.09
90.10	09010	DERMATOLOGY	0.635156	0	0	90.10
91.00	09100	EMERGENCY	0.145555	6,171	898	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.083341	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		315,773	71,127	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)		315,773		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/31/2022 11:29 am

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.236669	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.027748	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099365	0	0	54.00
60.00	06000	LABORATORY	0.149692	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.300527	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.241386	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.169642	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.078334	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.105684	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556357	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.455928	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326589	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.412870	0	0	90.00
90.01	09001	SENIOR CARE	0.767845	0	0	90.01
90.02	09002	GENERAL SURGERY	5.412493	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	3.501988	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.773503	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.829341	0	0	90.05
90.06	09006	OBGYN - DR SAUER	2.095240	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	3.886145	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	4.910441	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.265311	0	0	90.09
90.10	09010	DERMATOLOGY	0.635156	0	0	90.10
91.00	09100	EMERGENCY	0.145555	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.083341	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/31/2022 11:29 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,951,054	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,951,054	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	7,020,565	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	79,755	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,721,941	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,218,869	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,218,869	30.00
31.00	Primary payer payments	144	31.00
32.00	Subtotal (line 30 minus line 31)	1,218,725	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)	749,953	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	487,469	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	428,079	36.00
37.00	Subtotal (see instructions)	1,706,194	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,706,194	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	2,030,441	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)	-324,247	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	262,484	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,785,883		1,390,941	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	09/30/2021	662,800	09/30/2021	639,500	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)		662,800		639,500	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,448,683		2,030,441	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		117,632		324,247	6.02
7.00	Total Medicare program liability (see instructions)		3,331,051		1,706,194	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		145,056		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/30/2021	36,600		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		36,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		181,656		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		45,047		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		226,703		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/31/2022 11:29 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (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 - SWING BEDS | Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/31/2022 11:29 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	191,417	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	38,254	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	84	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	229,671	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	229,671	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	229,671	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,968	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	226,703	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	226,703	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	181,656	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	45,047	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/31/2022 11:29 am

Title XIX | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/31/2022 11:29 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,566,863	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,566,863	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,602,532	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,602,532	19.00
20.00	Deductibles (exclude professional component)	290,348	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,312,184	22.00
23.00	Coinsurance	13,727	23.00
24.00	Subtotal (line 22 minus line 23)	3,298,457	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	50,145	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	32,594	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	11,412	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,331,051	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,331,051	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,448,683	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-117,632	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	17,551	34.00

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

Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/31/2022 11:29 am

		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	9,484,097	0	0	0	1.00
2.00	Temporary investments	638,208	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	24,089,536	0	0	0	4.00
5.00	Other receivable	1,293,203	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-19,058,427	0	0	0	6.00
7.00	Inventory	1,399,283	0	0	0	7.00
8.00	Prepaid expenses	880,292	0	0	0	8.00
9.00	Other current assets	754,390	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)	19,480,582	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,001,138	0	0	0	12.00
13.00	Land improvements	3,355,876	0	0	0	13.00
14.00	Accumulated depreciation	-2,652,449	0	0	0	14.00
15.00	Buildings	37,464,364	0	0	0	15.00
16.00	Accumulated depreciation	-25,133,941	0	0	0	16.00
17.00	Leasehold improvements	857,272	0	0	0	17.00
18.00	Accumulated depreciation	-760,271	0	0	0	18.00
19.00	Fixed equipment	346,074	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	28,128,109	0	0	0	23.00
24.00	Accumulated depreciation	-25,436,480	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)	19,169,692	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	7,423,497	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	-1,720	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,421,777	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,072,051	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,212,967	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,956,936	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	6,965,238	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,135,141	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,952,558	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)	3,952,558	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,087,699	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	29,984,352				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)	29,984,352	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,072,051	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/31/2022 11:29 am

		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		31,870,590		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,886,238				2.00
3.00	Total (sum of line 1 and line 2)		29,984,352		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)		29,984,352		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)		29,984,352		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/31/2022 11:29 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,880,315		6,880,315	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,880,315		6,880,315	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,570,988		1,570,988	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,570,988		1,570,988	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,451,303		8,451,303	17.00
18.00	Ancillary services	17,700,116	149,113,729	166,813,845	18.00
19.00	Outpatient services	0	10,800	10,800	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	11,037,056	11,037,056	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	26,151,419	160,161,585	186,313,004	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		61,066,518		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		61,066,518		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Prepared: 5/31/2022 11:29 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	186,313,004	1.00
2.00	Less contractual allowances and discounts on patients' accounts	132,990,891	2.00
3.00	Net patient revenues (line 1 minus line 2)	53,322,113	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	61,066,518	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,744,405	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	23,890	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	124,341	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	13,271	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	219,637	22.00
23.00	Governmental appropriations	30,261	23.00
24.00	OTHER OPERATING INCOME	1,583,786	24.00
24.01	MOB	935,562	24.01
24.02	MISC INCOME	678,199	24.02
24.03	IGT	965,367	24.03
24.04	MISC INCOME	24,800	24.04
24.50	COVID-19 PHE Funding	1,259,053	24.50
25.00	Total other income (sum of lines 6-24)	5,858,167	25.00
26.00	Total (line 5 plus line 25)	-1,886,238	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,886,238	29.00