3 Signatory Title

4 Date

CEO

(Dated when report is electronica

## HARRI SON COUNTY HOSPI TAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b) payments made since the beginning of the cost reporting period				FORM APPROVED OMB NO. 0938-00 EXPIRES 03-31-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIC AND SETTLEMENT SUMMARY	CATION Pro	ovider CCN: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepa 5/31/2022 11:29	
PART I – COST REPORT STATUS					
Provider 1. [ X ] Electronically prepared cost report			Date: 5/31/20	22 Time: 11:	29 am
use only 2. [ ] Manually prepared cost report 3. [ 0 ] If this is an amended report enter the 4. [ F ] Medicare Utilization. Enter "F" for full	number of or "L" f	times the provider r for low.	esubmitted this c	cost report	
Contractor use only5. [1] Cost Report Status (1) As Submitted6. Date Received: 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended6. Date Received: Received: (7. Contractor No. (9. [N] Final Report (4) Reopened (5) Amended	ort for t	10. N 11. C his Provider CCN 12. [	PR Date: ontractor's Vendo 0]If line 5, cc number of tim	or Code: Jumn 1 is 4: En Nes reopened = 0	4 iter 1-9.
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMIN	STRATOR (	R PROVIDER(S)			
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINE ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTL ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	LAW. FUR	THERMORE, IF SERVICE	S IDENTIFIED IN T	HIS REPORT WERE	
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRA	ATOR OF PR	ROVI DER(S)			
I HEREBY CERTIFY that I have read the above certificar electronically filed or manually submitted cost repor- Statement of Revenue and Expenses prepared by HARRISO beginning 01/01/2021 and ending 12/31/2021 and to the are true, correct, complete and prepared from the bool applicable instructions, except as noted. I further corregarding the provision of health care services, and provided in compliance with such laws and regulations.	t and subm N COUNTY H best of m ss and rec ertify that that the s	hitted cost report an HOSPITAL (15–1331) Hy knowledge and beli Cords of the provider Ht I am familiar with	d the Balance She for the cost repo ef, this report a in accordance wi the laws and reg	eet and prting period and statement th gulations	
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		ELECTRONI C		
1	2		ATURE STATEMENT		
<sup>1</sup> Charles Wiley	Y	I have read and agrees statement. I certify signature on this ce binding equivalent c	that I intend my ertification be t	y electronic he legally	1
2 Signatory Printed Name Charles Wiley					2

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	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.

	AL AND HOSPITAL HEALTH CARE COMPLEX	I DENTIFICATION DATA	Provic	ler CCN	: 15-1331	Period: From 01/01/ To 12/31/	2021	Workshe Part I Date/Ti 5/31/20	me Pre	epare
	1.00	2.00		3.00		4	1.00			
	Hospital and Hospital Health Care Co		-							
	Street: 1141 ATWOOD STREET	PO Box:								1.
0	City: CORYDON	State: IN	Zip Cod			ty: HARRI SON	-		(-	2.
		Component Name	CCN	CBS				nt Syst		
			Number	Numb	er Type	Certified		0, or	·	-
		1.00	2.00	2.0	1 00	F 00	V	XVIII	XIX	-
	Userital and Userital Deced Company	1.00	2.00	3.0	0 4.00	5.00	6.00	7.00	8.00	
2	Hospital and Hospital-Based Componer		151001	2114	0 1	12/15/2005	N	0	0	
C	Hospi tal	HARRI SON COUNTY HOSPI TAL	151331	3114	0 1	12/15/2005	N			3
С	Subprovider - IPF	HUSFITAL								4
	Subprovider - IRF									5
	Subprovider - (Other)									6
0		HARRISON COUNTY SWING	15Z331	1599	0	08/14/2011	N	0	0	7
J	Swing Beds - SNF	BEDS	152331	1599	9	08/14/2011	IN			/
<b>`</b>	Swing Dodo NE	BEDS								
2	Swing Beds - NF									8
	Hospital-Based SNF									9.
	Hospital -Based NF									10
	Hospital -Based OLTC									11
	Hospital-Based HHA		1							12
	Separately Certified ASC		1							13
	Hospital -Based Hospice		-							14
	Hospital -Based Health Clinic - RHC		-							15
	Hospital -Based Health Clinic - FQHC		1							16
	Hospital-Based (CMHC) I		1							17
	Renal Dialysis		1							18
υ	Other			1				I		19
						From:		To		-
0	Cost Deporting Deried (my/dd/)					1.00		2.0		- 20
	Cost Reporting Period (mm/dd/yyyy)					01/01/20	121	12/31/	2021	20
U	Type of Control (see instructions)					9				21
				-	1 00	2.00		2 4	0	-
	Inpatient PPS Information				1.00	2.00		3. (	0	
	Does this facility qualify and is it	currently receiving pa	vments fo	r I	N	N	Т			22
0	disproportionate share hospital adju				IN	IN				22
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo		GIUNGIL							
	Did this hospital receive interim ur		ts for th	is	Ν	N				22.
	cost reporting period? Enter in colu				IN IN	IN IN				22
	the portion of the cost reporting period	riod occurring prior to	Octobor	1						
	Enter in column 2, "Y" for yes or "N	"Tou occurring piror to	n of the	r.						
	reporting period occurring on or aft			CUSI						
	is this a newly merged hospital that				Ν	N				22
าว					IN	IN IN				22
)2	payments to be determined at cost re		nctructio							
)2										
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)2	cost reporting period prior to Octob	" for no, for the porti per 1. Enter in column 2	on of the , "Y" for	yes						
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03	cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aff Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	" for no, for the porti- per 1. Enter in column 2 le cost reporting period aic reclassification fro- tods for delineating stat column 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column aic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column do for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column edicaid days on lines 24	on of the , "Y" for on or af m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds ( 3, "Y" for er 1. Ent he cost ructions) 99 beds ( n 3, "Y" and/or 2	yes ter o reas no er as or o eas no er as for 5						22
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)3	cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method	" for no, for the porti- ber 1. Enter in column 2 le cost reporting period dic reclassification fro- ds for delineating stat column 1, "Y" for yes or ig period prior to Octob no for the portion of t ter October 1. (see inst 100 but not more than 4 2.105)? Enter in column dic reclassification fro 8 delineations for stati column 1, "Y" for yes o ig period prior to Octob no for the portion of t ter October 1. (see inst 100 but not more than 4 2.105)? Enter in column dic reclassification fro 8 delineations for stati column 1, "Y" for yes o ig period prior to Octob no for the portion of t ter October 1. (see inst 100 but not more than 4 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if cens of identifying the days	on of the , "Y" for on or af m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds ( a, "Y" f m urban t stical ar r "N" for er 1. Ent he cost ructions) 99 beds ( n 3, "Y" and/or 2 us days, in this	yes ter o reas no er as or o eas no er as for 5 or 3		Ν				22
03	cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	" for no, for the porti er 1. Enter in column 2 he cost reporting period hic reclassification fro rds for delineating stat column 1, "Y" for yes or geperiod prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column hic reclassification fro delineations for stati column 1, "Y" for yes o geperiod prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if cens of identifying the days method used in the prio	on of the , "Y" for on or af m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds ( 3, "Y" f m urban t stical ar r "N" for er 1. Ent he cost ructions) 99 beds ( n 3, "Y" and/or 2 us days, in this r cost	yes ter o reas no er as or o eas no er as for 5 or 3		Ν				22

alth Financial Systems HARRISC DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ON COUNTY H	Provider CC	CN: 15-1331	Peri od:		Vorkshe	et S-2	
					1/2021	5/31/20	me Pre 022 11:	
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicai HMO day	s Mec	ther Ii cai d Iays	
	1.00	2.00	3.00	4.00	5.00		5.00	
<ul> <li>4.00 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.</li> <li>5.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid 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 3, HMO paid and eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.</li> </ul>	0			0		0	C	24. 00
		1	11		ural S D			-
6.00 Enter your standard geographic classification (not w		at the be	ginning of	1.0 the	2	2.0	JU	26.00
cost reporting period. Enter "1" for urban or "2" fo 7.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for r ication in	rural. If a column 2.	ppl i cabl e,		2			27.00
5.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods S	CH status i	n	0			35.00
				Begi nr 1. 0		<u>Endi</u> 2. (		-
6.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent date		script line	36 for num					36.00
7.00 If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.		er of perio	ds MDH stat	us	0			37.00
7.01 Is this hospital a former MDH that is eligible for tl accordance with FY 2016 OPPS final rule? Enter "Y" fi instructions)								37.0
8.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.								38.00
				Y/		Y/ 2. (		-
9.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)	), (íi), or the mileage	<sup>-</sup> (iii)? En e requireme	ter in colu nts in	ume N mn		N		39.0
D. 00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for				N		40.0
					V 1.00	XVIII 2.00	XI X 3.00	-
Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital payment	nt for disr	proportiona	te share in	accordance	N	N	N	45.00
with 42 CFR Section §412. 320? (see instructions) 6.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412. 348(f)? If yes, complete Wks	eption for	extraordi n	ary circums	tances	N	N	N	46.0
Pt. III. 7.00 [s this a new hospital under 42 CFR §412.300(b) PPS				0	N	N	N	47.0
8.00 <u>Is the facility electing full federal capital paymen</u> Teaching Hospitals	t? Enter '	Y" for yes	or "N" for	no.	N	<u>N</u>	N	48.0
6.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response	e to columr	1 is "Y", the prior	or if this year or pen	hospital ultimate				56.0
was involved in training residents in approved GME p year, and are you are impacted by CR 11642 (or appli Enter "Y" for yes; otherwise, enter "N" for no in co	cable CRs) Lumn 2.							
year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in co 7.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	cable CRs) lumn 2. period duri r yes or "M th of this Y", complet	ng which r " for no i cost repor e Workshee	n column 1. ting period	lf column ? Enter "Y				57.0
year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in co 7.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon	cable CRs) lumn 2. period duri r yes or "N th of this Y", complet l, if appli bursement f	ng which r I" for no i cost repor ce Workshee cable. For physici	n column 1. ting period t E-4. lf c	lf column ? Enter "Y olumn 2 is				57. C

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	<b>TA</b>	Provider C	F	veriod: rom 01/01/2021 o 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/31/2022 11:	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	1
0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col	85? (s umn 1. CR) NAHI	see If column 1	N			60.00
	Y/N	I ME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	1
<ul> <li>1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports</li> </ul>	N			0.00	0.00	61.00
ending and submitted before March 23, 2010. (see instructions) 1.02 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						61.0
ACA). (see instructions) 1.03 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)						61.0
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
1.05 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)						61.0
1.06 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)		N				61.0
	Pro	ogram Name	Program Code	IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
1.10 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	61.1
1.20 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	61.2
The arrest smelling dimension count.					1.00	
ACA Provisions Affecting the Health Resources and Se 2.00 Enter the number of FTE residents that your hospital				riod for which		62.0
your hospital received HRSA PCRE funding (see instruct 2.01 Enter the number of FTE residents that rotated from a	ctions) a Teachi	ng Health Cer	nter (THC) into			62.0
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovid 3.00 Has your facility trained residents in nonprovider so	er Sett	i ngs		and all Eater	N	63.00

alth Financial Systems DSPITAL AND HOSPITAL HEALTH CARE COMPL		ON COUNTY HOSPITAL ATA Provider C	CN· 15-1331 □	eri od:	u of Form CMS-2 Worksheet S-2	
JOPTIAL AND NUSPITAL REALTH CARE COMPL	EX IDENTIFICATION D			rom 01/01/2021	Part I	pared:
			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			-This base year	is your cost	reporti ng	
period that begins on or after Ju 4.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to roi settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 2)	yes, or your facili per of unweighted no ations occurring in number of unweighte ur hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio		0.00	0. 000000	64.00
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
	· · · · · · · · · · · · · · · · · · ·		FTEs Nonprovider Site	FTEs in Hospital	3/ (col . 3 + col . 4))	
-	1.00	2.00	3.00	4.00	5.00	-
5.00 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 Unweighted FTEs	0.00 Unweighted FTEs in	0.000000 Ratio (col. 1/ (col. 1 +	65.00
			Nonprovi der	Hospi tal	col. 2))	
			Si te 1.00	2.00	3.00	-
Section 5504 of the ACA Current	'ear FTE Residents i	n Nonprovider Settin				
beginning on or after July 1, 20	0	•				
5.00 Enter in column 1 the number of u FTEs attributable to rotations or Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	curring in all nonp nweighted non-prima I. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66. OC
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
			FTEs Nonprovider Site	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
7.00 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			0.00			67. OC

Heal th	Financial Systems HARRISON COUNTY HOSPITAL	In	Li eu	of Form	CMS-2	2552-10
HOSPI T		eriod: com 01/01/2 o 12/31/2	2021	Workshee Part I Date/Tir		
		12/31/2		5/31/202		
		-	1.00	2.00	3.00	
70 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub	orovi der?	N			70.00
	Enter "Y" for yes or "N" for no.				0	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for				0	71.00
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for					
	Column 3: If column 2 is Y, indicate which program year began during this cost reportin					
	(see instructions) Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		Ν			75.00
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in	the most			0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes o	r "N" for				
	no. Column 2: Did this facility train residents in a new teaching program in accordance 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)					
				1.00	C	
80.00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
	Is this a LTCH co-located within another hospital for part or all of the cost reporting	period? Er	nter	N		81.00
	"Y" for yes and "N" for no. TEFRA Providers					
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes		no.	Ν		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sectio §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	1				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.			Ν		87.00
		V		XIX		
	Title V and XIX Services	1.00		2.00	2	
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Y		90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	Ν		Ν		91.00
02.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see			N		92.00
92.00	instructions) Enter "Y" for yes or "N" for no in the applicable column.			IN		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.	Ν		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	Ν		Ν		94.00
95.00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	C	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	Ν		Ν		96.00
97.00	applicable column.  f line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	C	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	Y		Y		98.00
	column 1 for title V, and in column 2 for title XIX.					
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	Y		Y		98.01
00.00	title XIX.	Y		Y		98.02
90. UZ	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	T		T		90. UZ
98 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)	Ν		Ν		98.03
70.05	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	i v				70.05
98.04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	Ν		Ν		98.04
	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and					
98.05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on	Y		Y		98.05
	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.					
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	Y		Y		98.06
	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.					
105 00	Rural Providers					105 00
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	Y N				105.00 106.00
	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R	N				107.00
107.00	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)	IN				107.00
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded LPF and/or LRF unit(s)?					
	Enter "Y" for yes or "N" for no in column 2. (see instructions)					

Health Financial Systems HARRISON COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C			Worksheet S-2 Part I Date/Time Pre 5/31/2022 11:	epared:
			V 1.00	XI X 2.00	-
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	edul e? See 42	N		108.00
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3. 00 N	4.00 Y	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
			101	1.00	
110.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	r "N" for no. I	f yes,	N	110.00
			1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in t			N	2.00	111.00
Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	lumn 1 is Y, ticipating ir	enter the n column 2.			
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in th demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable.	period? "Y", enter e	N			112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N		(	0115.00
in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care ( psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	3" percent includes s) based on				11( 00
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.	ance? Enter	N			117.00
118.00 Is the mal practice insurance a claims-made or occurrence pol		1			118.00
if the policy is claim-made. Enter 2 if the policy is occurr	ence.	Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00 505,633	2.00	3.00	0118.01
					5110.01
118.02 Are malpractice premiums and paid losses reported in a cost	center other	than the	1.00 N	2.00	118.02
Administrative and General? If yes, submit supporting sched and amounts contained therein.					
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendmen	column 1, " alifies for t	Y" for yes or the Outpatient	Ν	N	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla	ntable device	es charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1			Y	5. 01	122.00
the Worksheet A line number where these taxes are included. Transplant Center Information					-
125.00 Does this facility operate a transplant center? Enter "Y" fo	r yes and "N	'for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en	ter the certi	fication date			126.00
in column 1 and termination date, if applicable, in column 2					127.00
127.00  f this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2					
128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2		rication date			128.00
129.00 If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2.	r the certifi	cation date in			129.00

From 01/01/2021 Par To 12/31/2021 Dat	the home 1.00 Y 2.00	epar
30.001f this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.         31.001f this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.         32.001f this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.         32.001f this is a organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.         33.00Removed and reserved         34.001f this is a organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.         34.001f this is an organ procurement organization, other the oPO number in column 1 and termination date, if applicable, in column 2.         30.00       If this is a and reme in column 2 the home office costs as defined in CMS Pub. 15-1, N         chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter the home office contractor name and contractor number.         41.00       2.00       3.00         1f this facility is part of a chain organization, enter on lines 141 through 143 the name and address of office and enter the home office contractor name and contractor number.       Contractor's Number:         42.00Street:       PO Box:       Contractor's Number:       1.00         43.00[f tosts for renal services are claimed on Wkst. A, line 74, are the cos	the home 1.00 Y 2.00	131 132 133 134 140 140 141 142 143 143
00.00   f this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.       Image: Control of Control o	the home 1.00 Y 2.00	131 132 133 134 140 140 141 142 143 143
11. 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.       Image: Column 1 and termination date, if applicable, in column 2.         12. 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.       Image: Column 1 and termination date, if applicable, in column 2.         13. 00 Removed and reserved       Image: Column 1 and termination date, if applicable, in column 2.         14. 00 If this is an organ procurement organization (0P0), enter the 0P0 number in column 1 and termination date, if applicable, in column 2.         14. 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)         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 office and enter the home office contractor name and contractor number.       Contractor's Number:         2.00 Street:       P0 Box:       21 p Code:         3.00 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.         46. 00 Has the cost allocation methodology changed from the previously filed cost report? N fen	the home 1.00 Y 2.00	132 133 134 140 140 141 142 143 144
12.00       If this is a Medicare certified is let transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.       In column 1 and termination date, if applicable, in column 2.         30.00       Removed and reserved       In column 1 and termination date, if applicable, in column 2.         44.00       If this is an organ procurement organization (OPO), enter the 0PO number in column 1 and termination date, if applicable, in column 2.       N         All Providers       In column 2.       N         00.00       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         10.00       2.00       3.00         If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of office and enter the home office contractor name and contractor number.       Contractor's Number:         10.00       Dax:       Zip Code:       2         10.00       State:       Zip Code:       2         11.00       State:       Zip Code:       1.00         12.00       State:       Zip Code:       1.00         13.00       State:       Zip Code:       1.00         15.00       If costs for renal services are claimed on Wkst. A, line 74, are the costs for inp	the home 1.00 Y 2.00	133 134 140 140 141 142 143 
in column 1 and termination date, if applicable, in column 2. 33.00 Removed and reserved 33.00 Removed and reserved 44.00 If this is an organ procurement organization (0PO), enter the 0PO number in column 1 and termination date, if applicable, in column 2. All Providers 0.00 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)  1.00 2.00  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 office and enter the home office contractor name and contractor number. (2.00 Street: 2.00 Street: 2.00 Street: 2.00 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. 6.00 Has the cost allocation methodology changed from the previously filed cost report? N	the home 1.00 Y 2.00	133 134 140 140 141 142 143 
4.00 If this is an organ procurement organization (0P0), enter the 0P0 number in column 1 and termination date, if applicable, in column 2. All Providers 0.00 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) 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 office and enter the home office contractor name and contractor number. 1.00 Name: 2.00 Street: 3.00City: Contractor's Name: 2.00Street: 3.00City: 5.00 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. 6.00 Has the cost allocation methodology changed from the previously filed cost report? N Enter "Y" for yes or "N" for no in column 2. 6.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 2. 6.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 2. 6.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 2. 6.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 2. 6.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 2. 6.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 2. 6.00 Has the cost allocation methodology changed from the previously filed cost report? Enter	the home 1.00 Y 2.00	134 140 141 142 143 144
0.00       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         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 office and enter the home office contractor name and contractor number.       Contractor's Number:         0.00       Name:       Contractor's Name:       Contractor's Number:         2.00       State:       Zip Code:         3.00       City:       State:       Zip Code:         4.00       Are provider based physicians' costs included in Worksheet A?       1.00       1.00         5.00       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.       N         6.00       Has the cost allocation methodology changed from the previously filed cost report? Negen enter with approval date (mm/dd/yyyy) in column 2.       N	the home 1.00 Y 2.00	141 142 143 
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of office and enter the home office contractor name and contractor number.       Contractor's Number:         11.00       Name:       Contractor's Name:       Contractor's Number:         12.00       Street:       P0 Box:       Zip Code:         33.00       City:       State:       Zip Code:         44.00       Are provider based physicians' costs included in Worksheet A?       1.00         15.00       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.       N         66.00       Has the cost allocation methodol ogy changed from the previously filed cost report? N enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	1.00 Y 2.00	142 143 
1.00 Name:       Contractor's Name:       Contractor's Number:         2.00 Street:       P0 Box:       Zip Code:         3.00 City:       State:       Zip Code:         4.00 Are provider based physicians' costs included in Worksheet A?       Image: Contractor's Number:         4.00 Are provider based physicians' costs included in Worksheet A?       Image: Contractor's Number:         5.00 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.       N         6.00 Has the cost allocation methodology changed from the previously filed cost report?       N         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.       Image: Contractor's Number:	1.00 Y 2.00	142 143 
12.00       Street:       P0 Box:       Zip Code:         13.00       City:       State:       Zip Code:         14.00       Are provider based physicians' costs included in Worksheet A?       1.00         15.00       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.       1.00         16.00       Has the cost allocation methodology changed from the previously filed cost report? N 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	1.00 Y 2.00	142 143 
14.00 Are provider based physicians' costs included in Worksheet A?         15.00 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.         16.00 Has the cost allocation methodology changed from the previously filed cost report?       N         Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	1.00 Y 2.00	144
1.00         15.00 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.         16.00 Has the cost allocation methodol ogy changed from the previously filed cost report?       N         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.	Y 2.00	_
15.00       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.         16.00       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.	2.00	_
<ul> <li>5.00 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.</li> <li>6.00 Has the cost allocation methodology changed from the previously filed cost report? N 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.</li> </ul>		145
<pre>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. 6.00 Has the cost allocation methodology changed from the previously filed cost report? N 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.</pre>		145
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.		
7 00Was there a change in the statistical basis? Enter "V" for yos or "N" for no		146
	1.00 N	147
8.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		148
9.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		149
Part A         Part B         Title V         Title V           1.00         2.00         3.00	itle XIX 4.00	-
Does this facility contain a provider that qualifies for an exemption from the application of the lower o		
or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13 5.00Hospital N N N	/	155
6. 00 Subprovi der – I PF N N N	N	156
7.00 Subprovi der – I RF N N N		157
8. 00 SUBPROVI DER 9. 00 SNF N N N		158
0. OOHOME HEALTH AGENCY N N N		160
1. 00 CMHC N N	N	161
	1.00	_
Multicampus 5.00Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs?	N	165
Enter "Y" for yes or "N" for no.		
Name         County         State         Zip Code         CBSA         FT           0         1.00         2.00         3.00         4.00	FE/Campus 5.00	-
5.00 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	0 166
	1 00	-
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act	1.00	-
7.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 7.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 8.00 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) 8.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship	Y	167 168 168

Health Financial Systems	HARRI SON COUNTY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	ICATION DATA		Period:	Worksheet S-2	2
				Part I Date/Time Pre	parad
			10 12/31/2021	5/31/2022 11:	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	date and ending da	te for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provider have	e any days for indi	viduals enrolled in	N	(	171.00
section 1876 Medicare cost plans reported of	on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If 1876 Medicare days in column 2. (see instru		nter the number of sectio	n		

<sup>5/31/2022 11:29</sup> am

05PT 1	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet S- Part II Date/Time Pr 5/31/2022 11	epared:
				Y/N	Date	_
	Compared Instructions Enter V for all VES responses. Enter N	for all NO r			2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS		esponses. En		the	-
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1.00
	reporting period? If yes, enter the date of the change in o	column 2. (see	Y/N	5) Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.0
			Y/N	Туре	Date	
	Financial Data and Dan-st-		1.00	2.00	3.00	-
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" t or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	for Compiled, ailable in	Y	С		4.00
. 00	those on the filed financial statements? If yes, submit rec		IN IN			5.00
			1	Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, i	s the provide	er N		6.00
. 00 . 00	is the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		7.0 8.0			
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	graduate medi	cal education	n N		9.0
0.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of	is.		N		10.00
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	Ν		11.0
					Y/N	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. 0 13. 0
4.00		ents waived? I	fyes, see in	nstructions.	Ν	14.0
F 00	Bed Complement	ng nariad2 If		structions	N	115.0
5.00	Did total beds available change from the prior cost reporti		<u>yes, see m</u>		t B	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	Ν		N		16. 0
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions)	Υ	03/21/2022	Y	03/21/2022	17.0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Ν		Ν		18.0
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.0

SPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1331	Period: From 01/01/2021 To 12/31/2021	U of Form CMS Worksheet S Part II Date/Time P 5/31/2022 1	-2 repared
	Descr	iption	Y/N	Y/N	
		0	1.00	3.00	
0.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.0
Report data for other abeserve the other adjustments.	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	Ν		N		21.0
				1.00	_
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHI LDRENS	HOSPI TALS)			
Capital Related Cost					
1.00 Have assets been relifed for Medicare purposes? If yes, see				N	22.0
4.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			0	N	23.0
<ul> <li>.00 Were new leases and/or amendments to existing leases entere If yes, see instructions</li> </ul>	ed into during	this cost r	reporting period?	N	24.0
6.00 Have there been new capitalized leases entered into during instructions.	the cost repo	orting period	l? If yes, see	N	25.0
0.00 Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost report	ing period?	lfyes, see	N	26.0
.00 Has the provider's capitalization policy changed during the copy. Interest Expense	e cost reporti	ng period? I	fyes, submit	N	27.0
.00 Were new loans, mortgage agreements or letters of credit en	ntered into du	ring the cos	st reporting	N	28. (
<ul> <li>period? If yes, see instructions.</li> <li>00 Did the provider have a funded depreciation account and/or</li> </ul>		ebt Service	Reserve Fund)	Ν	29. (
treated as a funded depreciation account? If yes, see instr .00 Has existing debt been replaced prior to its scheduled mature		debt?lfye	es, see	N	30. (
<ul> <li>instructions.</li> <li>Mas debt been recalled before scheduled maturity without is instructions.</li> </ul>	Ν	31.0			
Purchased Services 2.00 Have changes or new agreements occurred in patient care ser	vi ces furni sh	ed through c	contractual	N	32. (
arrangements with suppliers of services? If yes, see instru 10 If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to compet	itive bidding? If	N	33. (
no, see instructions. Provider-Based Physicians					
<ul> <li>.00 Are services furnished at the provider facility under an ar If yes, see instructions.</li> </ul>	rangement wit	h provider-b	based physicians?	Y	34.
6.00 If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ents with the	e provider-based	N	35.
			Y/N 1.00	Date 2.00	
Home Office Costs					
0.00 Were home office costs claimed on the cost report?			N		36.0
.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office	e? N		37.
If yes, see instructions. 0.00 If line 36 is yes , was the fiscal year end of the home off			of N		38.
the provider? If yes, enter in column 2 the fiscal year end 10.00 If line 36 is yes, did the provider render services to othe see instructions.			es, N		39.
100 If line 36 is yes, did the provider render services to the instructions.	home office?	lfyes, see	e N		40.
Cast Depart Droparar Contact Information	1.	00	2.	00	-
held by the cost report preparer in columns 1, 2, and 3,	CLINT		BRI LL		41.0
	BLUE AND COMPA	ANY			42.0
preparer. 2.00 Enter the telephone number and email address of the cost	502. 992. 3512		CBRI LL@BLUEAND	CO. COM	43.

Heal th Fi	inancial Systems HARRIS	SON COUNTY	/ HOSPI TAL	In Lieu	u of Form CMS-	2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNA	AI RE	Provider CCN: 15	Period: From 01/01/2021	Worksheet S-2 Part II	
						pared: 29 am
				_		
			3. 00			
Cc	ost Report Preparer Contact Information					
41.00 Er	inter the first name, last name and the title/posit	ion SE	ENIOR MANAGER			41.00
he	eld by the cost report preparer in columns 1, 2, a	and 3,				
re	especti vel y.					
42.00 Er	inter the employer/company name of the cost report					42.00
pi	reparer.					
43.00 Er	inter the telephone number and email address of the	e cost				43.00
re	eport preparer in columns 1 and 2, respectively.					

<sup>5/31/2022 11:29</sup> am

	Financial Systems	HARRI SON COUNT		N. 1E 1001		u of Form CMS		552-10
HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	JN: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet S- Part I Date/Time Pr		hared.
					10 12/31/2021	5/31/2022 1		
						I/P Days /		
						0/P Visits /	/	
						Trips		
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V		
		Line Number		Avai I abl e				
		1.00	2.00	3.00	4.00	5.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	21	7,66	55 71, 808. 00		0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
2 00	for the portion of LDP room available beds)							2 00
2.00	HMO and other (see instructions)							2.00
3.00 4.00	HMO IPF Subprovider HMO IRF Subprovider							3.00 4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF						0	4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation		21	7,66	5 71, 808. 00		0	7.00
7.00	beds) (see instructions)		21	7,00	71,808.00		4	7.00
8.00	INTENSI VE CARE UNI T	31.00	4	1, 46	0.00		0	8.00
9.00	CORONARY CARE UNIT	01.00		1, 1	0.00		Ĭ	9.00
10.00	BURN I NTENSI VE CARE UNI T							10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43.00					o	13.00
14.00	Total (see instructions)		25	9, 12	71, 808. 00			14.00
15.00	CAH visits						0	15.00
16.00	SUBPROVIDER - IPF							16.00
17.00	SUBPROVIDER - IRF							17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE							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		0		0			31.00
32.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room		0		U			32.00 32.01
	TUTAL ANCITTATY LADUL & GETTVELY LOOM							3Z. UI
32.01	outpatient days (see instructions)							
32. 01 33. 00	outpatient days (see instructions) LTCH non-covered days							33.00

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	HARRI SON COUNTY AL DATA	Provider CC	CN: 15-1331	Period: From 01/01/2021 To 12/31/2021	u of Form CMS-: Worksheet S-3 Part I Date/Time Pre 5/31/2022 11:	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 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, 99	92		1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	527 0	1, 132 0				2.00 3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	84	0	8	34		5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	942	0 64	3, 07	0 76		6.00 7.00
8.00 9.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT	216	0	56	53		8.00 9.00
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	7	72		12.00
14.00	Total (see instructions)	1, 158	101	4,4		488.47	
15.00	CAH visits	0	0	., .	0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24.00 24.10	HOSPICE HOSPICE (non-distinct part)				0		24.00
24.10	CMHC - CMHC				0		25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	
27.00	Total (sum of lines 14-26)	0	0		0.00		
28.00	Observation Bed Days		20	94			28.00
29.00	Ambul ance 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					33.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CCN: 15-1331		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/31/2022 11:	pared:
	Full Time Equivalents		Di s	charges		
Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	11.00	12.00	13.00	14.00	15.00	
<ol> <li>1.00 Hospital Adults &amp; 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)</li> <li>2.00 HM0 and other (see instructions)</li> <li>3.00 HM0 IPF Subprovider</li> <li>4.00 HM0 IRF Subprovider</li> <li>5.00 Hospital Adults &amp; Peds. Swing Bed SNF</li> <li>5.00 Hospital Adults &amp; Peds. Swing Bed SNF</li> <li>6.00 Hospital Adults and Peds. (exclude observation beds) (see instructions)</li> <li>3.00 INTENSIVE CARE UNIT</li> <li>9.00 CORONARY CARE UNIT</li> <li>9.00 SUBGICAL INTENSIVE CARE UNIT</li> <li>9.00 OTHER SPECIAL CARE (SPECIFY)</li> <li>13.00 NURSERY</li> <li>14.00 Total (see instructions)</li> <li>15.00 CAH visits</li> <li>16.00 SUBPROVIDER - IPF</li> <li>17.00 SUBPROVIDER - IRF</li> <li>18.00 SUBPROVIDER</li> <li>18.00 SUBPROVIDER</li> <li>19.00 SKILLED NURSING FACILITY</li> <li>10.00 OTHER LONG TERM CARE</li> <li>10.00 HOSPICE (non-distinct part)</li> <li>12.00 CMHC - CMHC</li> <li>23.00 AMBULATORY SURGICAL CENTER (D. P. )</li> <li>24.00 HOSPICE (non-distinct part)</li> <li>25.00 CMHC - CMHC</li> <li>26.00 RURAL HEALTH CLINIC</li> <li>26.25 FEDERALLY QUALIFIED HEALTH CENTER</li> <li>27.00 Total (sum of lines 14-26)</li> <li>28.00 Observation Bed Days</li> <li>29.00 Ambulance Trips</li> <li>30.00 Employee discount days (see instruction)</li> <li>31.00 Employee discount days (see instructions)</li> <li>32.01 Total ancillary labor &amp; delivery room</li> </ol>	0. 00 0. 00 0. 00	0	1	49 21 03 251 0 0 49 21	944	$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 12.00\\ 13.00\\ 13.00\\ 13.00\\ 14.00\\ 13.00\\ 13.00\\ 14.00\\ 22.00\\ 23.00\\ 24.00\\ 24.00\\ 24.00\\ 24.00\\ 24.00\\ 24.00\\ 24.00\\ 25.00\\ 24.00\\ 24.00\\ 23.00\\ 24.00\\ 24.00\\ 24.00\\ 23.00\\ 24.00\\ 25.00\\ 24.0$
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges				0 0		33.0 33.0

Heal th	Financial Systems HARRISON COUNTY H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCI		Period:	Worksheet S-1	0
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/31/2022 11:	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by li	ne 202 colum	n 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 Y	3.00
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplement If line 4 is no, then enter DSH and/or supplemental payments fi			ai 0 <i>?</i>	r o	4.00 5.00
6.00	Medicaid charges		u		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	nes 2 and 5; if	0	8.00		
	< zero then enter zero)					
9.00	Children's Health Insurance Program (CHIP) (see instructions for	or each line	e)		0	9.00
9.00 10.00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10)		l o			
12.00	Difference between net revenue and costs for stand-alone CHIP	0				
	enter zero)	-				
10.00	Other state or local government indigent care program (see inst					10.00
13.00 14.00	Net revenue from state or local indigent care program (Not incl Charges for patients covered under state or local indigent care				0	
14.00	10)			TH THES 0 OF	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14	4)			0	15.00
16.00	Difference between net revenue and costs for state or local ind	digent care	program (li	ne 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and state	e/local indi	gent care progra	ams (see	
17.00	Private grants, donations, or endowment income restricted to fu	unding chari	ity care		0	17.00
18.00	Government grants, appropriations or transfers for support of I				0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	l indigent o	care program	s (sum of lines	0	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire fac	cility	554, 16	0 1, 469, 006	2, 023, 166	20.00
	(see instructions)			.,,	_,,	
21.00	Cost of patients approved for charity care and uninsured disco	unts (see	145, 06	1, 469, 006	1, 614, 070	21.00
~~ ~~	instructions)					
22.00	Payments received from patients for amounts previously written charity care	orr as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		145, 06	1, 469, 006	1, 614, 070	23.00
		· ·				
24.00	Dese the amount on Line 20 column 2 include channes for notice			- C atau limit	1.00	24.00
24.00	Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care		ond a rength	or stay limit	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the stay limit		care progra	m's length of	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see in:	structions)			5, 257, 687	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see his		ructions)		520, 063	
27.01	Medicare allowable bad debts for the entire hospital complex (				800, 098	
28.00	Non-Medicare bad debt expense (see instructions)				4, 457, 589	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	pense (see i	instructions	)	1, 446, 907	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus li	ino 20)			3, 060, 977 3, 060, 977	
51.00	Trotal uniernibul seu anu uncompensateu care cost (TTHE 19 plus II	ine 30)			3,000,977	1 31.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	HARRI SON COUNT	Y HOSPITAL Provider CO	°N· 15-1331 P	In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
RECENC					rom 01/01/2021		
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col.3+-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
1 00	GENERAL SERVICE COST CENTERS		1 524 0/0	1 524 0/0	100.054	1 700 000	1 00
1. 00 1. 01	00100 NEW CAP REL COSTS-BLDG & FLXT 00101 MOB		1, 534, 869 620, 393				1.00 1.01
1.01	00102 AMB DEPR		020, 343	020, 343			
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		994, 291	994, 291			2.00
2.01	00201 AMB EQUI P		0	0	246, 438		2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	192,063	1,045,172				
5. 01 5. 02	00590 ADMI NI STRATI VE & GENERAL 00570 ADMI TTI NG	1, 681, 232 516, 455	4, 977, 926 168, 927				
5.02 5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	395, 285	896, 915				
7.00	00700 OPERATION OF PLANT	264, 804	1, 334, 645				
8.00	00800 LAUNDRY & LINEN SERVICE	23, 289	238, 991	262, 280	0		8.00
9.00	00900 HOUSEKEEPI NG	529, 169	325, 728				9.00
10.00	01000 DI ETARY	456, 214	441, 372				
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0 691, 198	0 216, 452	-			
14.00	01400 CENTRAL SERVICES & SUPPLY	218, 416	2, 350, 642	2, 569, 058			
16.00	01600 MEDICAL RECORDS & LIBRARY	645, 573	315, 258				
17.00	01700 SOCIAL SERVICE	299, 647	88, 113	387, 760	0	387, 760	17.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	0.777.000	4 55 4 000	5 000 000	100.115	5 400 000	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	3, 777, 939 477, 684	1, 554, 999 152, 233				1
	04300 NURSERY	477,004	132, 233				43.00
	ANCILLARY SERVICE COST CENTERS					,	
50.00	05000 OPERATI NG ROOM	1,006,361	776, 632	1, 782, 993	-256, 908	1, 526, 085	50.00
53.00	05300 ANESTHESI OLOGY	0	1, 221, 262				53.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	1, 067, 108 848, 577	1, 025, 644 1, 765, 606				
65.00	06500 RESPIRATORY THERAPY	040, 577	595, 094				
66.00	06600 PHYSI CAL THERAPY	371, 367	67, 859				
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	48, 836	48, 836	67.00
68.00	06800 SPEECH PATHOLOGY	0	46				
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	460, 503	167, 042	627, 545 0			
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	1		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	349, 315	2,083,791	2, 433, 106			1
	OUTPATIENT SERVICE COST CENTERS					1	
90.00	09000 CLINIC	24, 483	15, 868				90.00
90. 01 90. 02	09001 SENI OR CARE 09002 GENERAL SURGERY	84, 871 809, 036	137, 891 300, 666				
	09003 HARRI SON CRAWFORD HEALTHCARE	577, 979	277, 275				
	09004 CORYDON MEDI CAL ASSOCI ATES	518, 135	254, 763	772, 898	-23, 288		
	09005 ORTHOPEDIC SURGERY - DR KLINE	1, 259, 659	629, 795				
90.06	09006 OBGYN - DR SAUER	531, 396	236, 146				
90. 07 90. 08	09007 FIRST CAPITAL MEDICAL GROUP 09008 SOUTH HARRISON FAMILY MEDICINE	0	0 0	-	1 - 1 -		
90.08 90.09	09009 PALN MANAGEMENT	159, 479	33, 653	-			
90.10	09010 DERMATOLOGY	475, 298	146, 197				
91.00	09100 EMERGENCY	1, 813, 134	833, 798			2, 630, 902	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	2, 225, 802	1, 675, 393	3, 901, 195	-537, 654	3, 363, 541	95.00
75.00	SPECIAL PURPOSE COST CENTERS	2,220,002	1,075,575	3, 701, 173	557,054	3, 303, 341	/5.00
113.00	11300 I NTEREST EXPENSE		171, 766			0	113.00
118.00		22, 751, 471	29, 673, 292		1, 729, 868	54, 154, 631	118.00
100.00	NONREI MBURSABLE COST CENTERS		0		2		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 4, 735, 077	0 3, 333, 859				190.00
	07950 MARKETI NG	-, , 33, 0, 7	0, 333, 839	0,000,930	1, 727, 308		192.00
	07951 PHYSI CI AN BI LLI NG	360, 156	212, 663	572, 819	0	572, 819	194.01
	07952 MOB	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	J200. 00

Health Financial Systems RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	HARRI SON COUN	ITY HOSPITAL Provider CCN: 15-1331	In Lieu Period:	u of Form CMS-2552-10 Worksheet A
RECEASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	UF EAPENSES		From 01/01/2021 To 12/31/2021	
Cost Conton Description	Adjustments	Net Expenses		5/31/2022 11:29 am
Cost Center Description	(See A-8)	For		
		Allocation		
GENERAL SERVICE COST CENTERS	6.00	7.00		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	-27, 357	1, 705, 866		1.00
1. 01 00101 MOB	0			1.01
1.02 00102 AMB DEPR	0	· · ·		1.02
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2. 01 00201 AMB EQUIP	0			2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-47,085			2.01
5. 01 00590 ADMINI STRATI VE & GENERAL	-1, 536, 030			5. 01
5. 02 00570 ADMI TTI NG	0			5.02
5. 03 00580 CASHI ERING/ACCOUNTS RECEIVABLE 7. 00 00700 OPERATION OF PLANT	0			5.03
8. 00 00800 LAUNDRY & LINEN SERVICE	0			8.00
9. 00 00900 HOUSEKEEPI NG	0			9.00
10. 00 01000 DI ETARY	0			10.00
11.00 01100 CAFETERIA	-124, 341	391, 861		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	0			13.00 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		F 120 022		20,00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	0			30.00 31.00
43. 00 04300 NURSERY	0			43.00
ANCILLARY SERVICE COST CENTERS	-			
50.00 O5000 OPERATING ROOM	0			50.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	-1, 191, 120	15, 804 2, 005, 610		53.00 54.00
60. 00 06000 LABORATORY	-3, 648			60.00
65. 00 06500 RESPI RATORY THERAPY	-1, 921	519, 156		65.00
66.00 06600 PHYSI CAL THERAPY	0			66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	48, 836 8, 084		67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	2, 432, 923		73.00
90. 00 09000 CLINIC	0	32, 677		90.00
90. 01 09001 SENI OR CARE	-17, 444			90.01
90. 02 09002 GENERAL SURGERY	-836, 588			90.02
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE 90. 04 09004 CORYDON MEDI CAL ASSOCI ATES	-438, 120 -471, 524			90. 03 90. 04
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE	-1, 225, 835			90.05
90.06 09006 0BGYN - DR SAUER	-603, 634			90.06
90. 07 09007 FIRST CAPITAL MEDICAL GROUP	-312, 781	897, 046		90.07
90. 08 09008 SOUTH HARRI SON FAMILY MEDICINE 90. 09 09009 PAIN MANAGEMENT	-198, 239 -185, 883			90.08 90.09
90. 10 09010 DERMATOLOGY	-411, 654			90.10
91.00 09100 EMERGENCY	0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
95. 00 09500 AMBULANCE SERVICES	-14, 078	3, 349, 463		95.00
SPECIAL PURPOSE COST CENTERS	-14,078	0, 07, 7, 100		75.00
113.00 11300 I NTEREST EXPENSE	0			113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-7, 660, 553	46, 494, 078		118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			190.00
194. 00 07950 MARKETI NG	0	0		194.00
194. 01 07951 PHYSI CI AN BI LLI NG	0			194.01
194.02 07952 MOB 200.00    TOTAL (SUM OF LINES 118 through 199)	-7, 660, 553			194. 02 200. 00
200.00 TITAL (SUM OF LINES TTO LITUUYIT 199)	-7,000,003	55,405,705		1200.00

h Financial Systems SSIFICATIONS		HARRI SON COUNT	Y HOSPITAL Provider CCN: 15-1	In Lieu of For 1331 Period: Worksh	<u>rm CMS-2552</u> eet A-6
				From 01/01/2021 To 12/31/2021 Date/T	ime Prepar 022 11:29
	Increases			575172	022 11.29
Cost Center 2.00	Line # 3.00	Sal ary 4. 00	0ther 5.00		
A - SUPPLIES	3.00	4.00	5.00	· · · · · · · · · · · · · · · · · · ·	
MEDICAL SUPPLIES CHARGED TO	71.00	0	2, 731, 954		1
PATI ENTS					
	0.00 0.00	0	0		2
	0.00	0	0		4
	0.00	0	Ő		5
	0.00	0	0		6
	0.00	0	0		
	0.00 0.00	0	0		8
	0.00	0	0		10
	0.00	0	Ő		11
	0.00	0	0		12
	0.00	0	0		13
	0.00	0	0		14
	0.00	0	0		15
	0.00 0.00	0	0		16
	0.00	0	0		18
	0.00	Ö	Ö		19
	0.00	0	0		20
	0.00	0	0		21
	0. 00 0. 00	0	0		22
	0.00	0	0		23
		o	2,731,954		24
B - IMPLANTABLE DEVICES	I		2, , 0 , , , 0 ,		
IMPL. DEV. CHARGED TO	72.00	0	916, 554		1
PATI ENT	+				
C - AMBULANCE CAPITAL		0	916, 554		
AMB DEPR	1. 02	0	58, 866		1
AMB EQUIP	2.01	0	246, 438		2
0		0	305, 304		
D - INTEREST	1 00		171 7//		
NEW CAP REL COSTS-BLDG & FLXT	1.00	0	171, 766		1
	+		171, 766		
E - EKG					
ELECTROCARDI OLOGY	69.00	14, 800	19, 483		1
	0.00	0	0		2
	0. 00 0. 00	0	0 0		3
		14,800	19, 483		-
F - NURSERY	I	11,000	17,100		
NURSERY	43.00	166, 443	<u>0</u>		1
0		166, 443	0		
G - THERAPY SPEECH PATHOLOGY	(0.00	( 70/	1 242		
OCCUPATIONAL THERAPY	68. 00 67. 00	6, 796 41, 296	1, 242 7, 540		1
	07.00	48, 092	<u> </u>		2
H – CAFETERIA	1				
CAFETERI A	11.00	262, 369	25 <u>3, 8</u> 33		1
		262, 369	253, 833		
I - DEPRECIATION RECLASS NEW CAP REL COSTS-BLDG &	1.00	0	26, 588		1
FIXT	1.00	Ч Ч	20, 500		
NEW CAP REL COSTS-MVBLE	2.00	о	3, 970		2
EQUI P	↓	↓			
		0	30, 558		
J - AMBULANCE WORKERS COMP EMPLOYEE BENEFITS DEPARTMENT	4.00	0	184, 389		1
TOTALS		o	18 <u>4, 389</u> 184, 389		
K - MISCELLANEOUS BENEFITS					
EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26, 362		1
	0.00	0	0		2
	0.00	º_			3
TOTALS L - FCMG PROVIDER BASED		0	26, 362		
FIRST CAPITAL MEDICAL GROUP	90.07	856, 664	397, 571		1
I THE WEDTORE UNOUF		856, 664			1 1

Heal th	Financial Systems		HARRI SON COUN	TY HOSPI TAL		In Lieu	u of Form CMS-	-2552-10
RECLASS	RECLASSI FI CATI ONS			Provider CCN: 15-1331		Period: From 01/01/2021	Worksheet A-	6
						To 12/31/2021	Date/Time Pr 5/31/2022 11	epared: :29 am
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	M - SHFM PROVIDER BASED							
1.00	SOUTH HARRISON FAMILY	90.08	286, 311	133, 695				1.00
	MEDICINE							
	TOTALS		286, 311	133, 695				
500.00	Grand Total: Increases		1, 634, 679	5, 180, 251				500.00

						From 01/01/2021 To 12/31/2021	Date/Time Prepare 5/31/2022 11:29 a
	Cost Center	Decreases	Salary	Othor	What A 7 Dof	-	
	6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	<u>Wkst. A-7 Ref</u> 10.00	<u>.</u>	
	A - SUPPLIES	7.00	0.00	7.00	10.00		
. 00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 549, 625		0	1.
00	ADULTS & PEDIATRICS	30.00	0	26, 672		0	2.
00	I NTENSI VE CARE UNI T	31.00	0	7, 231		0	3.
00	NURSERY	43.00	0	18		0	4.
			0				
00	OPERATI NG ROOM	50.00	-	256, 908		0	5.
00	ANESTHESI OLOGY	53.00	0	14, 338		0	6.
00	RADI OLOGY-DI AGNOSTI C	54.00	0	87, 142		0	7.
00	LABORATORY	60.00	0	161, 090		0	8.
00	RESPI RATORY THERAPY	65.00	0	54, 534		0	9.
0. 00	PHYSI CAL THERAPY	66.00	0	56		0	10.
. 00	ELECTROCARDI OLOGY	69.00	0	10, 650		0	11.
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	183		0	12.
3.00		90.00	0	7,674		0	13.
1.00	GENERAL SURGERY	90.02	0	1, 767		0	14.
			0			0	
5.00	HARRISON CRAWFORD HEALTHCARE	90.03	0	19, 063		-	15.
. 00	CORYDON MEDICAL ASSOCIATES	90.04	0	23, 288		0	16.
. 00	ORTHOPEDIC SURGERY - DR	90. 05	0	351, 688		0	17.
	KLINE						
3.00	OBGYN - DR SAUER	90.06	0	4, 759		0	18.
9.00	FIRST CAPITAL MEDICAL GROUP	90.07	0	44, 408		0	19.
. 00	SOUTH HARRISON FAMILY	90.08	0	30, 944		0	20.
	MEDICINE		-			-	
. 00	PALN MANAGEMENT	90.09	0	12, 927		0	21.
	-		0			0	
2.00	DERMATOLOGY	90.10	-	3, 591		-	22.
3.00	EMERGENCY	91.00	0	15, 507		0	23.
. 00	AMBULANCE_SERVICES	95.00	0	4 <u>7, 8</u> 91		Ō	24.
	0		0	2, 731, 954			
	B - IMPLANTABLE DEVICES						
00	MEDICAL SUPPLIES CHARGED TO	71.00	0	916, 554		0	1.
	PATIENTS						
				916, 554		7	
	C - AMBULANCE CAPITAL						
00	AMBULANCE SERVICES	95.00	0	305, 304		9	1.
00	AMBOEANCE SERVICES	0.00	0	000,004		9	2.
00			— — — <del>o</del>			<u></u>	2.
	D - INTEREST		Ч	303, 304			
00	INTEREST EXPENSE	113.00	0	171, 766	1	1	1.
00			0		'	4	1.
			U	171, 766			
	E – EKG						
00	LABORATORY	60.00	14, 207	0		0	1.
00	RESPI RATORY THERAPY	65.00	0	19, 483		0	2.
00	EMERGENCY	91.00	523	0		0	3.
00	AMBULANCE SERVICES	95.00	70	0		0	4.
			14, 800	19, 483		-	
	F - NURSERY		11/000	177 100			
00	ADULTS & PEDIATRICS	30.00	166, 443	0		0	1.
00			166, 443	<u>o</u>		<u>u</u>	1.
			100, 443	0			
~ ~	G - THERAPY		(0.000	0.700			
00	PHYSI CAL THERAPY	66.00	48, 092	8, 782		0	1.
00		0.00	0	0		0	2.
	0		48, 092	8, 782			
	H – CAFETERIA						
00	DI ETARY	10.00	262, 369	253, 833		0	1.
			262, 369	253, 833		-	1
	I - DEPRECIATION RECLASS		202,007	200,000			
00	PHYSICIANS' PRIVATE OFFICES	102.00		20 550		0	1.
00	PHISICIANS PRIVATE OFFICES	192.00	0	30, 558		9	
00		0.00	0	0		9	2.
	TOTALS		0	30, 558			
	J - AMBULANCE WORKERS COMP						
00	AMBULANCE_SERVICES	95.00	0	<u>184, 3</u> 89		0	1.
	TOTALS		0	184, 389		7	
	K - MI SCELLANEOUS BENEFI TS			,,			
00	ADMI NI STRATI VE & GENERAL	5.01	0	708		0	1.
			0	585			
00	MEDI CAL RECORDS & LI BRARY	16.00	U			0	2.
00	PHYSICIANS' PRIVATE OFFICES	192.00	0	25,069		Q	3.
	TOTALS		0	26, 362			
	L - FCMG PROVIDER BASED						
00	PHYSICIANS' PRIVATE OFFICES	<u> </u>	<u>856, 6</u> 64	<u>397, 5</u> 71		0	1.
	TOTALS		856, 664	397, 571			

192.00

286, 311

286, 311

1,634,679

13<u>3, 6</u>95

133, 695

5, 180, 251

0

HARRISON COUNTY HOSPITAL

Provider CCN: 15-1331

Period:

From 01/01/2021 To 12/31/2021

TOTALS

500.00 Grand Total: Decreases

M - SHFM PROVIDER BASED PHYSICIANS' PRIVATE OFFICES

1.00

Health Financial Systems

RECLASSI FI CATI ONS

1.00

500.00

In Lieu of Form CMS-2552-10

Worksheet A-6

Heal th	Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONO	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1331	Period: From 01/01/2021 To 12/31/2021		pared:
				Acqui si ti on	S		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F 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	1
10.00	Total (line 8 minus line 9)	80, 310, 607	346, 074		0 346,074	7, 503, 848	10.00
		Endi ng	Fully		· ·		
		Bal ance	Depreciated				
			Assets				
		6.00	7.00	1			
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F 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
	Total (line 8 minus line 9)	73, 152, 833	0				10.00

<sup>5/31/2022 11:29</sup> am

Heal th	n Financial Systems	HARRI SON COUN			In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2021 To 12/31/2021		
			SU	IMMARY OF CAP	TAL		
	Cost Center Description	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 WOR	KSHEET A, COLUN	NN 2, LINES 1 a	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, 47	7 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		73, 47	7 98, 355	0	3.00
		SUMMARY O	F CAPI TAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at					
		ed Costs (see	9 through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN					
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	1(7,000	0				2.01
3.00	Total (sum of lines 1-2)	167, 302	3, 149, 553				3.00

	Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/31/2022 11:	pared:
		COM	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed 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 C			<b>.</b>	-		
1.00 1.01 1.02	NEW CAP REL COSTS-BLDG & FIXT MOB AMB DEPR	45, 024, 724 0 0			4 0. 615488 0 0. 000000 0 0. 000000	0	1.00 1.01 1.02
2. 00 2. 01	NEW CAP REL COSTS-MVBLE EQUIP	28, 128, 109 0	0	28, 128, 10	9 0. 384512 0 0. 000000		2.00 2.01
3.00	Total (sum of lines 1-2)	73, 152, 833	0	73, 152, 83	3 1.000000	0	3.00
		ALLOCA	TION OF OTHER (			F CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relat ed 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 C				T		
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		0 1, 463, 102		1.00
1.01	MOB	0	0	)	0 297, 913		1.01
1.02 2.00	AMB DEPR NEW CAP REL COSTS-MVBLE EQUIP	0			0 58,866 0 998,261		1.02 2.00
2.00	AMB EQUIP	0			0 998, 201		2.00
3.00	Total (sum of lines 1-2)	0			0 3, 064, 580		3.00
3.00			SL	JMMARY OF CAPI		01,701	5.00
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see		Capital -Relat		
			instructions)	,	ed Costs (see instructions)	9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	NEW CAP REL COSTS-BLDG & FIXT	144, 409			0 0	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1.00
1.01	MOB	73, 477	0		0 167, 302		1.01
1.02	AMB DEPR	0			0	58, 866	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0			0 0	998, 261	2.00 2.01
2.01 3.00	Total (sum of lines 1-2)	217, 886	98, 355		0 167, 302	246, 438 3, 629, 824	
5.00		217,000	0,303	1	107, 302	3, 027, 024	5.00

	Financial Systems MENTS TO EXPENSES		HARRI SON COUNT	Provider CCN: 15-1331	In Lie Period: From 01/01/2021	u of Form CMS-2 Worksheet A-8	
					To 12/31/2021	Date/Time Pre 5/31/2022 11:	pared: 29 am
			Г	Expense Classification of From Which the Amount i			
					5		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2) 1.00	2.00	3.00	4.00	Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		-	NEW CAP REL COSTS-BLDG &	1.00	0	1.00
1. 01	2) Investment income - MOB		ON	ЛОВ	1. 01	0	1.01
1. 02	(chapter 2) Investment income - AMB DEPR		04	AMB DEPR	1. 02	0	1.02
2.00	(chapter 2) Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2.00	0	2.00
	REL COSTS-MVBLE EQUIP (chapter 2)			EQUI P			
2. 01	Investment income - AMB EQUIP (chapter 2)		04	AMB EQUIP	2. 01	0	2.01
3.00	Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		о		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay	А	-2, 9894	ADMI NI STRATI VE & GENERAL	5. 01	0	7.00
	stations excluded) (chapter 21)						
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00		
10.00	Provider-based physician adjustment	A-8-2	-3, 868, 844			0	
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00		
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -124, 341 (	CAFETERIA	0.00 11.00		
15.00	Rental of quarters to employee and others		0		0.00	0	
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and	В	-13, 271	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	abstracts Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00		1
21.00	interest, finance or penalty		0		0.00	0	21.00
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	OF	RESPI RATORY THERAPY	65.00		23.00
201 00	therapy costs in excess of limitation (chapter 14)						20100
24.00	Adjustment for physical	A-8-3	OF	PHYSI CAL THERAPY	66.00		24.00
05 65	therapy costs in excess of limitation (chapter 14)						05
25.00	Utilization review - physicians' compensation		0	*** Cost Center Deleted **	* 114.00		25.00
26.00	(chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
26. 01	COSTS-BLDG & FIXT Depreciation - MOB			FIXT MOB	1.01	0	26.01
	Depreciation - AMB DEPR			AMB DEPR	1. 02		26.02

Heal th Financial	Systems	
	(DENOE0	

HARRI SON COUNTY HOSPI TAL

In Lieu of Form CMS-2552-10

Health Financial Systems		HARRI SON COUN	TY_HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				eriod:	Worksheet A-8	
				rom 01/01/2021 0 12/31/2021	Date/Time Pre	nared
				12/01/2021	5/31/2022 11:	
			Expense Classification on	Worksheet A		
			To/From Which the Amount is <sup>-</sup>	to be Adjusted		
Cost Center Descriptio	n Basis/Code	Amount	Cost Center	Line #	Wkst. A-7	
cost center bescriptio	(2)	Amount	cost center		Ref.	
	1.00	2.00	3.00	4.00	5.00	
27.00 Depreciation - NEW CAP REL			NEW CAP REL COSTS-MVBLE	2.00		27.00
COSTS-MVBLE EQUIP			EQUI P			
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	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
therapy costs in excess of						
limitation (chapter 14)						
30.99 Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.99
instructions)						
31.00 Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
pathology costs in excess of	T I					
limitation (chapter 14)				0.00		22.00
32.00 CAH HIT Adjustment for		0		0.00	0	32.00
Depreciation and Interest 33.00 MISC INCOME - A&G	В	10 677	ADMI NI STRATI VE & GENERAL	5.01	0	33.00
33.01 MISC INCOME - LABORATORY	В		LABORATORY	60.00	-	33.00
33. 02 CLINIC RENT	A		SENI OR CARE	90.01	0	
33. 02 CLINIC RENT	A		GENERAL SURGERY	90.01	-	33.02
33.04 CLINIC RENT	A		HARRISON CRAWFORD HEALTHCARE	90.02		•
33. 05 CLINIC RENT	A		CORYDON MEDICAL ASSOCIATES	90.03		
33. 06 CLINIC RENT	A		FIRST CAPITAL MEDICAL GROUP	90.07	0	
33. 07 CLINIC RENT	A		SOUTH HARRISON FAMILY	90.08	-	•
			MEDICINE	,0.00	U U	00.07
33.08 CLINIC RENT	A		ORTHOPEDIC SURGERY - DR	90.05	0	33.08
			KLI NE			
33.09 CLINIC RENT	A	-46, 224	OBGYN – DR SAUER	90.06	0	33.09
33.10 FOUNDATION SALARY	В	-30, 261	ADMINISTRATIVE & GENERAL	5.01	0	33.10
34.00 INTEREST	В	-18, 696	NEW CAP REL COSTS-BLDG &	1.00	11	34.00
			FIXT			
34.01 PROVIDER TAX FEE	A	-1, 307, 198	ADMI NI STRATI VE & GENERAL	5.01	0	
35.00 UNNECESSARY BORROWING	A		NEW CAP REL COSTS-BLDG &	1.00	11	35.00
			FIXT			
36. 00 CRNA	A		ANESTHESI OLOGY	53.00		
37.00 LOBBYING FEES	A		ADMINISTRATIVE & GENERAL	5.01	0	
38.00 MARKETING EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.01	0	
39.00 NURSE PRACTITIONER OFFSET -	A	-85, 035	HARRISON CRAWFORD HEALTHCARE	90.03	0	39.00
SALARY		0/ 574		00.04		10.00
40.00 NURSE PRACTITIONER OFFSET -	A	-96, 5/1	CORYDON MEDICAL ASSOCIATES	90.04	0	40.00
SALARY	Λ	00.240		90. 05	0	40.01
40. 01 NURSE PRACTITIONER OFFSET - SALARY	A		ORTHOPEDIC SURGERY - DR KLINE	90.05	U	40.01
41.00 NURSE PRACTITIONER OFFSET -	А		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
BENEFITS	A .	-47,000	EWI LOTEL DENELTIS DEFARTMENT	4.00	U U	41.00
50.00 TOTAL (sum of lines 1 thru 4	19)	-7,660,553				50.00
(Transfer to Worksheet A,		,,000,000				
column 6, line 200.)						
						·

(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.

Heal th	Financial Syste	ems	HARRI SON COU	INTY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (		Period: From 01/01/2021		
						To 12/31/2021	Date/Time Pre 5/31/2022 11:	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider 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		LABORATORY	32, 995					2.00
3.00		RESPI RATORY THERAPY	1, 921		C	-		3.00
4.00		GENERAL SURGERY	761, 479				0	4.00
5.00 6.00		HARRISON CRAWFORD HEALTHCARE	261, 758 283, 063				0	5.00 6.00
7.00	90.05	ORTHOPEDIC SURGERY - DR KLINE	1, 076, 176			-	0	7.00
8.00		OBGYN - DR SAUER	557, 410	557, 410	C	0	0	8.00
9.00	90.07	FIRST CAPITAL MEDICAL GROUP	194, 939	176, 929	18, 010	0	0	9.00
10.00		SOUTH HARRISON FAMILY	145, 639	145, 639	C	0	0	10.00
		MEDICINE	105 000	105 000				
11.00			185, 883			0	0	
12.00 13.00		DERMATOLOGY EMERGENCY	411, 654 299, 279			0	0	12.00 13.00
14.00		AMBULANCE SERVICES	14, 078			0	0	
200.00	/0.00		4, 343, 928				-	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE Limit	Conti nui ng	Share of col.	of Mal practi ce I nsurance	
	1.00	2.00	8.00	9.00	Education 12.00	12 13.00	14.00	
1.00		SOCIAL SERVICE	0.00					1.00
2.00		LABORATORY	0					2.00
3.00		RESPI RATORY THERAPY	0	0		0	0	3.00
4.00		GENERAL SURGERY	0	0	-	0	0	4.00
5.00		HARRISON CRAWFORD HEALTHCARE	0	0	-	0	0	5.00
6.00		CORYDON MEDICAL ASSOCIATES	0	0	-	0	0	6.00
7.00		ORTHOPEDIC SURGERY - DR KLINE	0	0	C	0	0	7.00
8.00		OBGYN - DR SAUER	0	0	0	0	0	8.00
9.00		FIRST CAPITAL MEDICAL GROUP	0	0	-	0	0	9,00
10.00		SOUTH HARRISON FAMILY	0	0	C	0	0	10.00
		MEDICINE						
11.00		PAIN MANAGEMENT	0	0	C	0	0	11.00
12.00		DERMATOLOGY	0	0	-	0	0	
13.00			0	0	-	0	0	
14.00 200.00	95.00	AMBULANCE SERVICES		0		0	0	14.00 200.00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
		I denti fi er	Component Share of col.	Limit	Di sal l'owance			
	1 00	2.00	<u>14</u> 15. 00	16.00	17.00	18.00		
1.00	1.00	2.00 SOCIAL SERVICE	15.00	16.00 0		18.00		1.00
2.00		LABORATORY	0			3, 300		2.00
3.00		RESPI RATORY THERAPY	0	0	-	1, 921		3.00
4.00	1	GENERAL SURGERY	0	0	C	759, 674		4.00
5.00	1	HARRISON CRAWFORD HEALTHCARE	0	0	-	261, 758		5.00
6.00		CORYDON MEDICAL ASSOCIATES	0	0	-			6.00
7.00		ORTHOPEDIC SURGERY - DR KLINE	0	0	_	1, 067, 535		7.00
8.00	1	OBGYN - DR SAUER		0	-	557, 410		8.00
9. 00 10. 00	90.08	FIRST CAPITAL MEDICAL GROUP SOUTH HARRISON FAMILY	0	0		176, 929 145, 639		9.00 10.00
		MEDICINE						
11.00			0	0		185, 883		11.00
12.00				0	-	411, 654		12.00
13.00 14.00	1	EMERGENCY AMBULANCE SERVICES		-		14, 078		13.00 14.00
200.00	,5.00		0					200.00
_00.00	1	1	. 0	. 0		1 0,000,044	1	_00.00

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	HARRI SON COUNT FURNI SHED BY	TY HOSPITAL Provider CC		In Lie Period: From 01/01/2021 To 12/31/2021 Respiratory Therapy	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 5/31/2022 11: Cost	-3 pared:
						1.00	
1.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide	s) (see instruc	tions)			52 780	1.00
2.00 3.00 4.00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi Number of unduplicated days in which therapy nor therapist was on provider site (see inst	assistant was				/80 0 0	2.00 3.00 4.00
5.00 6.00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the instructions)	rvisors or ther apy assistants	(include only	visits made l		0 0	5.00 6.00
7.00 8.00	Standard travel expense rate Optional travel expense rate per mile					5.50 0.00	
		Supervi sors 1.00	Therapists 2.00	Assi stants 3.00	Ai des 4.00	Trai nees 5.00	
9.00	Total hours worked	0.00	8, 760. 00	0.0	0.00	0.00	
10. 00 11. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0. 00 34. 83	69.66 34.83	0. 0 0. 0		0.00	10.00 11.00
12. 00 12. 01	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		D		12.00 12.01
13.00 13.01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13.00 13.01
		IR				1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00 15.00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2,					0 610, 222	14.00 15.00
16. 00 17. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a	line10)	ratory therapy	vorlines 14	-16 for all	0 610, 222	16.00 17.00
18.00	others) Aides (column 4, line 9 times column 4, line		5 15			0	
19.00	Trainees (column 5, line 9 times column 5, l					0	
20.00	Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respirator					610, 222 hol ogy or	20.00
	occupational therapy, line 9, is greater tha amount from line 20. Otherwise complete lin		no entries on	lines 21 and	22 and enter on	line 23 the	
21.00	Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3,	ainees (line 17		m of columns	1 and 2, line 9	0.00	21.00
22.00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)		,			0	
23.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVE	L EXPENSE COMP	UTATION - PRO	IVIDER SITE	610, 222	23.00
24.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	
26.00 27.00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				3 and 4 for all	0 0	
28.00	others) Total standard travel allowance and standard	travel expense	at the provic	ler site (sum	of lines 26 and	0	28.00
	27) Optional Travel Allowance and Optional Trave	I Expense					
29.00 30.00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3		d 2, line 12 )			0	
31.00	Subtotal (line 29 for respiratory therapy or		9 and 30 for a	II others)		0	31.00
32.00	Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	s 1 and 2, line	13 for respir	atory therapy	or sum of	0	32.00
33.00	Standard travel allowance and standard trave	I expense (line	28)			0	33.00
34.00 35.00	Optional travel allowance and standard trave Optional travel allowance and optional trave					0	34.00 35.00
	Part I V - STANDARD AND OPTIONAL TRAVEL ALLOW. Standard Travel Expense				/ICES OUTSIDE PR		
36.00	Therapists (line 5 times column 2, line 11)					0	
37.00 38.00							37.00 38.00
39.00	Standard travel expense (line 7 times the su		d 6)			0	39.00
40.00	Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12.		2. Line 10)			0	40.00
41.00	Assistants (column 3, line 12.01 times colum	0	41.00				
42.00 43.00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the su	0					
	Total Travel Allowance and Travel Expense -				owing three lin		
44.00	46, as appropriate. Standard travel allowance and standard trave	I expense (sum	of lines 38 ar	nd 39 - see in	nstructions)	0	44.00
	022 11:29 am				,	-	

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet A-8 Parts I-VI Date/Time Pre 5/31/2022 11:	pared.
					Respi ratory Therapy	Cost	
						1.00	
	Optional travel allowance and standard trave					0	
6.00	Optional travel allowance and optional trave	expense (sum Therapists	of lines 42 an Assistants	nd 43 - see ir Aides	structions) Trainees	0 Total	46.00
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
7.00	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	0.0	0.00	0.00	47.00
8.00	Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.00
9.00	Total overtime (including base and overtime	0.00	0.00	0.0	0.00		49.00
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						-
0. 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	0.0	0.00	0.00	50.00
1.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.0	0.00	0.00	51.00
2.00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	69.66	0.00	0.0	0.00		52.00
3.00	(see instructions) Overtime cost limitation (line 51 times line	09.00	0.00		o 0.00		53.0
4.00	52) Maximum overtime cost (enter the lesser of	0	0		0 0		54.0
5.00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.00
6. 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		o o	0	56.00
				<u> </u>			
						1.00	
7.00	Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)	AND EXCESS CUST	ADJUSTMENT			610, 222	57.00
8.00	Travel allowance and expense - provider site	(from lines 33	3, 34, or 35))			0	1
9.00	Travel allowance and expense - Offsite servic	ces (from lines	s 44, 45, or 4	6)		0	
	Overtime allowance (from column 5, line 56) Equipment cost (see instructions)					0	
	Supplies (see instructions)						62.0
	Total allowance (sum of lines 57-62)					610, 222	
	Total cost of outside supplier services (from					487, 684	
5.00	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	3 - II negative	e, enter zero)			0	65.0
00.00	Line 26 = line 24 for respiratory therapy or	sum of lines 2	24 and 25 for a	all others		0	100. 0
	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	y therapy or su	um of lines 3 a	and 4 for all	others		100. 0 100. 0
01.00	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	y therapy or su	um of lines 3 a	and 4 for all	others	0	101.0
01.01	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31					0	101. 0 101. 0
	LINE 35 CALCULATION						1.00 0
02.00	Line 31 = line 29 for respiratory therapy or	sum of lines 3	29 and 30 for :	all others	I	0	1102 0
	Line $31 =$ line 29 for respiratory therapy or Line $32 =$ line 8 times columns 1 and 2, line 13 for all others				mns 1-3, line		102. 0 102. 0

Heal th	Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CO		eriod: ^om 01/01/2021	Worksheet B Part I	
				Te		Date/Time Pre	pared:
				CAPI TAL REL	ATED COSTS	5/31/2022 11:	29 am
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	MOB	AMB DEPR	NEW MVBLE EQUI P	
		Allocation				LQUIT	
		(from Wkst A					
		col. 7) 0	1.00	1.01	1.02	2.00	
	GENERAL SERVICE COST CENTERS					2100	
	00100 NEW CAP REL COSTS-BLDG & FIXT	1, 705, 866	1, 705, 866				1.00
1. 01 1. 02	00101 MOB 00102 AMB DEPR	620, 393 58, 866	0		58,866		1.01
	00200 NEW CAP REL COSTS-MVBLE EQUIP	998, 261	-	_	,	998, 261	2.00
2.01	00201 AMB EQUIP	246, 438	0 515			0	
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL	1, 400, 901 5, 122, 420	2, 515 252, 861		0	1, 472 147, 973	
5.02	00570 ADMI TTI NG	685, 382	0	0	0	0	1
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00700 OPERATI ON OF PLANT	1, 292, 200	0	-	0	0	
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	1, 599, 449 262, 280	197, 249 11, 517		0	115, 429 6, 740	
9.00	00900 HOUSEKEEPI NG	854, 897	24, 669	0	0	14, 436	•
	01000 DI ETARY	381, 384	71, 781	0	0	42,006	
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	391, 861 907, 650	35, 859 6, 035		0	20, 984 3, 532	
	01400 CENTRAL SERVICES & SUPPLY	1, 019, 433	0	-	0	0	
	01600 MEDICAL RECORDS & LIBRARY	946, 975	40, 046		0	23, 435	1
17.00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	387, 760	2, 414	0	0	1, 413	17.00
30.00	03000 ADULTS & PEDIATRICS	5, 139, 823	272, 636	0	0	159, 541	30.00
	03100 I NTENSI VE CARE UNI T	622, 686	36, 425		0	21, 316	•
43.00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	166, 604	7, 544	0	0	4, 415	43.00
50.00	05000 OPERATING ROOM	1, 526, 085	222, 824	0	0	130, 395	50.00
	05300 ANESTHESI OLOGY	15, 804	0		0	0	
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	2, 005, 610 2, 435, 238	116, 743 61, 358		0	68, 317 35, 906	•
	06500 RESPIRATORY THERAPY	519, 156	13, 353		0	7, 814	•
	06600 PHYSI CAL THERAPY	382, 296	45, 176		0	26, 437	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	48, 836 8, 084	0	-	0	0	67.00 68.00
	06900 ELECTROCARDI OLOGY	651, 178	22, 934	-	0	13, 421	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 815, 400	54, 769		0	32, 051	71.00
	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	916, 554 2, 432, 923	0 15, 415	-	0	0 9, 021	72.00
	OUTPATIENT SERVICE COST CENTERS	2,432,723	15, 415	0	0	9, 021	/3.00
	09000 CLI NI C	32, 677	9, 556		0	5, 592	
	09001 SENI OR CARE 09002 GENERAL SURGERY	205, 318 271, 347	0	10, 849 14, 466	0	0	
	09003 HARRI SON CRAWFORD HEALTHCARE	398, 071	0		0	0	
90.04	09004 CORYDON MEDICAL ASSOCIATES	278, 086	0	78, 001	0	0	•
	09005 ORTHOPEDIC SURGERY - DR KLINE 09006 OBGYN - DR SAUER	311, 931	0	100, 176 30, 055	0	0	
	09007 FIRST CAPITAL MEDICAL GROUP	159, 149 897, 046	0		0	0	1
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	190, 823	0	33, 671	0	0	90.08
	09009 PAIN MANAGEMENT	-5, 678	0		0	0	
	09010 DERMATOLOGY 09100 EMERGENCY	206, 250 2, 630, 902	0 82, 468		0	0 48, 260	90.10 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,000,702	02, 100	, C	Ŭ	10,200	92.00
05 00	OTHER REIMBURSABLE COST CENTERS	2 240 4/2			F0.0//	0	
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	3, 349, 463	0	0	58, 866	0	95.00
	11300 INTEREST EXPENSE						113.00
118.00		46, 494, 078	1, 606, 147	447, 071	58, 866	939, 906	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 247	0	0	5 997	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	6, 339, 068	83, 185		0		192.00
	07950 MARKETING	0	0	-	0		194.00
	07951 PHYSICIAN BILLING 07952 MOB	572, 819 0	6, 287 0	0 173, 322	0		194.01 194.02
200.00			0	175, 522	0		200.00
201.00	Negative Cost Centers		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

Heal th	Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod:	Worksheet B	
					rom 01/01/2021 o 12/31/2021	Part     Date/Time Pre	pared:
						5/31/2022 11:	
	Cost Center Description	AMB EQUIP	EMPLOYEE	Subtotal	ADMI NI STRATI V	ADMI TTI NG	
			BENEFITS	Subtotal	E & GENERAL		
			DEPARTMENT				
	1	2.01	4.00	4A	5.01	5.02	
1 00	GENERAL SERVICE COST CENTERS	1 1			1		1 00
1.00 1.01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB						1.00 1.01
1.01	00102 AMB DEPR						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 AMB EQUI P	246, 438					2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 404, 888				4.00
5.01	00590 ADMI NI STRATI VE & GENERAL	0	85, 408	5, 612, 393			5.01
5.02		0	26, 236	711, 618		795, 183	5.02
5.03 7.00	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00700 OPERATI ON OF PLANT	0	20, 081 13, 452	1, 312, 281 1, 925, 579		0	5.03 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 183	281, 720		0	8.00
9.00	00900 HOUSEKEEPI NG	0	26, 882	920, 884		0	9.00
10.00	01000 DI ETARY	0	9, 848	505, 019		0	10.00
11.00	01100 CAFETERI A	0	13, 329	462, 033	54, 257	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	35, 114	952, 331		0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	11, 096	1, 030, 529		0	14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	32, 796	1, 043, 252		0	16.00
17.00	01700 SOCIAL SERVICE	0	15, 222	406, 809	47, 772	0	17.00
30, 00	03000 ADULTS & PEDIATRICS	0	183, 472	5, 755, 472	675, 865	41, 822	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	24, 267	704, 694		7, 102	31.00
43.00	04300 NURSERY	0	8, 455	187, 018		7,457	43.00
	ANCI LLARY SERVICE COST CENTERS	• • • •					
50.00	05000 OPERATING ROOM	0	51, 124	1, 930, 428		64, 991	50.00
53.00	05300 ANESTHESI OLOGY	0	0	15, 804		13, 560	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	54, 210	2, 244, 880		173, 130	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	42, 387 0	2, 580, 713 540, 323		119, 695 10, 706	60.00 65.00
66.00	06600 PHYSI CAL THERAPY	0	16, 423	470, 332		13, 775	
67.00	06700 OCCUPATI ONAL THERAPY	0	2,098	50, 934		1, 815	
68.00	06800 SPEECH PATHOLOGY	0	345	8, 429		778	
69.00	06900 ELECTROCARDI OLOGY	0	24, 146	711, 679	83, 572	51, 576	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 902, 220		23, 522	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATI ENT	0	0	916, 554		13, 429	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	17, 746	2, 475, 105	290, 652	42, 815	73.00
90.00	09000 CLINIC	0	1, 244	49,069	5, 762	998	90.00
90.01	09001 SENI OR CARE	0	4, 312	220, 479		1, 604	90.01
	09002 GENERAL SURGERY	0	41, 100	326, 913		327	90.02
90.03	09003 HARRI SON CRAWFORD HEALTHCARE	0	29, 362	492, 910	57, 882	764	90.03
90.04	09004 CORYDON MEDICAL ASSOCIATES	0	26, 322	382, 409		2, 743	90.04
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	0	63, 992	476, 099		3, 191	90.05
90.06	09006 OBGYN - DR SAUER	0	26, 995	216, 199		579	90.06
90.07	09007 FIRST CAPITAL MEDICAL GROUP	0	43, 519	997, 458		1, 385	90.07
90. 08 90. 09	09008 SOUTH HARRISON FAMILY MEDICINE 09009 PAIN MANAGEMENT	0	14, 545 8, 102	239, 039 25, 265		269 566	90.08 90.09
90.09 90.10	09010 DERMATOLOGY	0	24, 146	255, 483		2, 252	90.09
91.00	09100 EMERGENCY	0	92, 082	2, 853, 712		143, 021	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			C			92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	246, 438	113, 069	3, 767, 836	442, 457	51, 311	95.00
110 00	SPECIAL PURPOSE COST CENTERS	1			1		112 00
	SUBTOTALS (SUM OF LINES 1 through 117)	246 420	1 204 110	4E 041 004	1 720 220	705 102	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	246, 438	1, 204, 110	45, 961, 904	4, 738, 239	795, 183	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	16, 244	1, 908	0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	182, 482	6, 653, 414			192.00
194.00	07950 MARKETI NG	0	0	C	0	0	194.00
	07951 PHYSICIAN BILLING	0	18, 296	601, 081			194.01
	07952 MOB	0	0	173, 322		0	194.02
200.00			~	C		~	200. 00 201. 00
201.00 202.00		0 246, 438	0 1, 404, 888	53, 405, 965	-	0 795, 183	
202.00		2.0, 400	., 104, 000	33, 100, 700	0,012,070	, , 5, 105	

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	HARRI SON COUN	TY HOSPITAL Provider C	CN: 15-1331 P	In Lie eriod:	u of Form CMS-2 Worksheet B	2552-10
0001 //					rom 01/01/2021	Part I Date/Time Pre 5/31/2022 11:	pared: 29 am
	Cost Center Description	CASHI ERI NG/AC COUNTS RECEI VABLE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	27 411
		5. 03	7.00	8.00	9.00	10.00	
4 9 9	GENERAL SERVICE COST CENTERS	<u>г г</u>					1
	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB						1.00
	00102 AMB DEPR						1.01
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 AMB EQUIP						2.01
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL						4.00 5.01
	00570 ADMINISTRATIVE & GENERAL						5.01
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 466, 382					5.03
	00700 OPERATION OF PLANT	0	2, 151, 700				7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	19, 774 42, 354	334, 576 0	1, 071, 377		8.00 9.00
	01000 DI ETARY	0	123, 241	3, 734	63, 189	754, 487	10.00
	01100 CAFETERI A	0	61, 567	0	31, 567	0	11.00
	01300 NURSING ADMINISTRATION	0	10, 362	0	5, 313	0	13.00
	01400 CENTRAL SERVI CES & SUPPLY 01600 MEDI CAL RECORDS & LI BRARY	0	0 68, 755	0	0 35, 252	0	14.00 16.00
	01700 SOCIAL SERVICE	0	4, 145	0	2, 125	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS		.,	-	_,		
	03000 ADULTS & PEDI ATRI CS	77, 130	468, 093		240, 004	637, 758	30.00
	03100 I NTENSI VE CARE UNI T	13,098	62, 538	46, 674 0	32, 065 6, 641	116, 729	31.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	13, 753	12, 952	0	0, 041	0	43.00
50.00	05000 OPERATI NG ROOM	119, 860	382, 568	24, 207	196, 152	0	50.00
53.00	05300 ANESTHESI OLOGY	25, 009	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	319, 153	200, 437	41, 640	102, 769	0	54.00
	06000 LABORATORY 06500 RESPI RATORY THERAPY	220, 749 19, 745	105, 345 22, 926		54, 013 11, 755	0	60.00 65.00
	06600 PHYSI CAL THERAPY	25, 405	77, 563		39, 768	0	66.00
	06700 OCCUPATI ONAL THERAPY	3, 348	0	-	0	0	67.00
	06800 SPEECH PATHOLOGY	1, 435	0	0	0	0	68.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	95, 119 43, 380	39, 375 94, 034	9, 087 0	20, 189 48, 213	0	69.00 71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	24, 767	0	0	40, 213	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	78, 962	26, 466	0	13, 570	0	73.00
00.00	OUTPATIENT SERVICE COST CENTERS	1.044	1/ 10/	447	0.440		
	09000 CLINIC 09001 SENIOR CARE	1, 841 2, 958	16, 406 0			0	90.00 90.01
	09002 GENERAL SURGERY	602	0	355	0	0	90.01
	09003 HARRI SON CRAWFORD HEALTHCARE	1, 408	0	13	0	0	90.03
	09004 CORYDON MEDICAL ASSOCIATES	5, 059	0		0	0	90.04
	09005 ORTHOPEDIC SURGERY - DR KLINE	5,885	0	148 752	0	0	90.05 90.06
	09006 OBGYN - DR SAUER 09007 FIRST CAPITAL MEDICAL GROUP	1, 067 2, 555	0	504	0	0	90.08
	09008 SOUTH HARRISON FAMILY MEDICINE	496	0	151	0	0	90.08
	09009 PAIN MANAGEMENT	1, 043	0	444	0	0	90.09
		4, 154	0	1, 774		0	90.10
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	263, 769	141, 590	93, 341	72, 597	0	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>					72.00
95.00	09500 AMBULANCE SERVI CES	94, 632	0	18, 851	0	0	95.00
110.00	SPECIAL PURPOSE COST CENTERS	1 1					110.00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	1, 466, 382	1, 980, 491	327, 881	983, 594	754, 487	113.00
110.00	NONREI MBURSABLE COST CENTERS	1,400,302	1, 700, 471	527,001	703, 374	734,407	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17, 594		9, 021		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	142, 821	6, 695	73, 228		192.00
	07950 MARKETING 07951 PHYSICIAN BILLING	0	0 10, 794	0	0 5, 534		194.00 194.01
	OF STREETISTOLAN DILLING	0	10, 794	0	0,004		
194.01	07952 MOB	O	0	0	0	0	194.02
194. 01 194. 02 200. 00	Cross Foot Adjustments	0	0	0	0		200.00
194. 01 194. 02	Cross Foot Adjustments Negative Cost Centers	0 0 1, 466, 382	0 0 2, 151, 700	0 0 334, 576	0 0 1, 071, 377		200. 00 201. 00

Health Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2021	Worksheet B Part I	
				To 12/31/2021	Date/Time Pre 5/31/2022 11:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	MEDI CAL	SOCI AL	
		ADMI NI STRATI O N	SERVICES & SUPPLY	RECORDS & LI BRARY	SERVI CE	
	11.00	13.00	14.00	16.00	17.00	
1.00 OC100 NEW CAP REL COSTS-BLDG & FIXT	1					1.00
1. 01 00101 MOB						1.00
1.02 00102 AMB DEPR						1.02
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2. 01 00201 AMB EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00590 ADMI NI STRATI VE & GENERAL 5. 02 00570 ADMI TTI NG						5.01 5.02
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.03
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						7.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00  01100  CAFETERI A 13. 00  01300  NURSI NG ADMI NI STRATI ON	609, 424 17, 874					11.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	12, 083			7		14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	29, 207				44.0 050	16.00
17. 00 01700 SOCI AL SERVI CE I NPATI ENT ROUTI NE SERVI CE COST CENTERS	6, 830	0	37	7 0	468, 058	17.00
30. 00 03000 ADULTS & PEDI ATRI CS	140, 456				323, 649	
31. 00  03100   I NTENSI VE CARE UNI T 43. 00  04300   NURSERY	16, 528				60, 901 83, 508	31.00 43.00
ANCI LLARY SERVICE COST CENTERS	0,420	24, 130		1 12,210	03, 300	+3.00
50. 00 05000 OPERATING ROOM	44, 619				0	•
53. 00  05300  ANESTHESI OLOGY 54. 00  05400  RADI OLOGY-DI AGNOSTI C	44, 215	-	2, 50 25, 64		0	
60. 00 06000 LABORATORY	30, 265	0	244, 22	1 195, 981	0	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	9, 274	-	5, 66 1, 32		0	
67. 00 06700 OCCUPATI ONAL THERAPY	1, 193			0 2,972	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	192 14, 873		1: 6, 68		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 873		441, 63		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	C	-			0	•
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	6, 753	0	3, 29	3 70, 103	0	73.00
90. 00 09000 CLINIC	847		-		0	•
90. 01 09001 SENI OR CARE 90. 02 09002 GENERAL SURGERY	2, 309				0	90.01 90.02
90. 02 09002 GENERAL SURGERT 90. 03 09003 HARRI SON CRAWFORD HEALTHCARE	11, 102		1, 91 3, 76		0	1
90. 04 09004 CORYDON MEDI CAL ASSOCI ATES	13, 295				0	
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE 90. 06 09006 0BGYN - DR SAUER	18, 990		0,00		0	
90. 07 09007 FIRST CAPITAL MEDICAL GROUP	25, 340		11, 27		0	•
90. 08 09008 SOUTH HARRI SON FAMILY MEDICINE	7,696		7,85		0	
90. 09 09009 PALN MANAGEMENT 90. 10 09010 DERMATOLOGY	924 7, 157		14 3, 19		0	
91.00 09100 EMERGENCY	66, 284	248, 889			0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	C	0	38, 57	5 84, 014	0	95.00
SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE	1					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	558, 033	1, 097, 712	1, 163, 62	7 1, 301, 951	468, 058	•
NONREI MBURSABLE COST CENTERS				-		
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	32, 343	0		0 0 0 0		190.00 192.00
194. 00 07950 MARKETI NG	C	0		0 0	0	194.00
194. 01 07951 PHYSICIAN_BILLING 194. 02 07952 M0B	19, 048					194.01 194.02
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)	609, 424	1, 097, 712	1, 163, 62	7 1, 301, 951	468, 058	202.00

Health Financial Systems	HARRI SON COUN	TY HOSPITAL		In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1331	Period:	Worksheet B
				From 01/01/2021 To 12/31/2021	Part I Date/Time Prepared: 5/31/2022 11:29 am
Cost Center Description	Subtotal	Intern &	Total		5/31/2022 11:29 am
		Residents			
		Cost & Post Stepdown			
		Adjustments			
	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101 MOB					1.01
1.02 00102 AMB DEPR					1.02
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2. 01 00201 AMB EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 01 00590 ADMI NI STRATI VE & GENERAL					5.01
5. 02 00570 ADMI TTI NG 5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 02 5. 03
7. 00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE					8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY					9.00
11. 00 01100 CAFETERIA					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
16. 00  01600   MEDI CAL RECORDS & LI BRARY 17. 00  01700   SOCI AL SERVI CE					16.00 17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS	9,076,752	0	9,076,7		30.00
31. 00  03100   I NTENSI VE CARE UNI T 43. 00  04300   NURSERY	1, 223, 940 376, 098	0	1, 223, 9 376, 0		31.00 43.00
ANCI LLARY SERVI CE COST CENTERS	0,0,070	V	0,0,0		10.00
50. 00 05000 OPERATI NG ROOM	3, 308, 511	0	3, 308, 5		50.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	80, 935 3, 698, 923	0	80, 9 3, 698, 9		53.00 54.00
60. 00 06000 LABORATORY	3, 854, 035	0	3, 854, 0		60.00
65. 00 06500 RESPI RATORY THERAPY	692, 096	0	692, 0		65.00
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	715, 224 66, 243	0	715, 2 66, 2		66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	13, 110	0	13, 1		68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 172, 449	0	1, 172, 4		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2,814,892	0	2, 814, 8 1, 316, 9		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 316, 994 3, 007, 719		3,007,7		72.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C 90. 01 09001 SENI OR CARE	88, 668 264, 891	0	88, 6 264, 8		90.00 90.01
90. 02 09002 GENERAL SURGERY	380, 141	0	380, 1		90.01
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE	575, 247	0	575, 2		90.03
90. 04 09004 CORYDON MEDICAL ASSOCIATES	456, 358	0	456, 3		90.04
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE 90. 06 09006 0BGYN - DR SAUER	569, 250 260, 761	0	569, 2 260, 7		90. 05 90. 06
90. 07 09007 FIRST CAPITAL MEDICAL GROUP	1, 157, 912	0	1, 157, 9		90.07
90. 08 09008 SOUTH HARRI SON FAMILY MEDICINE	284, 015		284, 0		90.08
90. 09 09009 PALN MANAGEMENT 90. 10 09010 DERMATOLOGY	32, 278 307, 707	0	32, 2 307, 7		90. 09 90. 10
91. 00 09100 EMERGENCY	4, 477, 847	0	4, 477, 8		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	4, 497, 676	0	4, 497, 6	76	95.00
SPECIAL PURPOSE COST CENTERS	T, T, T, 070		-, -, 0		73.00
113.00 11300 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	44, 770, 672	0	44, 770, 6	12	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	44, 767	0	44, 7	67	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	7, 689, 809	0	7, 689, 8		192.00
194. 00 07950  MARKETI NG 194. 01 07951  PHYSI CI AN BI LLI NG	0 707, 042	0	707, 0	0	194. 00 194. 01
194. 02 07952 MOB	193, 675	0	193, 6		194.01
200.00 Cross Foot Adjustments	0	0		0	200.00
201.00 Negative Cost Centers	0 53 405 045	0		0	201.00
202.00   TOTAL (sum lines 118 through 201)	53, 405, 965	0	53, 405, 9	00	202.00

Heal th	Financial Systems	HARRI SON COUN	TY_HOSPI TAL		In Lieu	u of Form CMS-	2552-10	
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2021	Worksheet B Part II		
					To 12/31/2021	Date/Time Pre 5/31/2022 11:	pared:	
			CAPITAL RELATED COSTS					
	Cost Center Description	Directly	NEW BLDG &	МОВ	AMB DEPR	NEW MVBLE		
		Assigned New	FI XT			EQUI P		
		Capital Related Costs						
		0	1.00	1.01	1. 02	2.00		
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00	
1.01	00101 MOB						1.01	
1.02 2.00	00102 AMB DEPR 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.02 2.00	
2.00	00201 AMB EQUIP						2.00	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 515			1, 472		
5. 01 5. 02	00590 ADMINI STRATI VE & GENERAL 00570 ADMITTI NG	0	252, 861 0			147, 973 0	1	
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0			0	•	
7.00 8.00	00700 OPERATION OF PLANT	0	197, 249 11, 517			115, 429	•	
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	24, 669			6, 740 14, 436	•	
10.00	01000 DI ETARY	0	71, 781		0	42, 006	10.00	
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	35, 859 6, 035			20, 984 3, 532		
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0,035			3, 332 0	1	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	40, 046			23, 435		
17.00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	2, 414	(	0 0	1, 413	17.00	
30.00	03000 ADULTS & PEDIATRICS	0	272, 636	(	0 0	159, 541	30.00	
31.00	03100 I NTENSI VE CARE UNI T	0	36, 425			21, 316	•	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	7, 544		0 0	4, 415	43.00	
50.00	05000 OPERATING ROOM	0	222, 824	(	0 0	130, 395	50.00	
53.00	05300 ANESTHESI OLOGY	0	0			0		
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	116, 743 61, 358		-	68, 317 35, 906		
65.00	06500 RESPI RATORY THERAPY	0	13, 353			7, 814	•	
66.00	06600 PHYSI CAL THERAPY	0	45, 176			26, 437	•	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0			0	•	
69.00	06900 ELECTROCARDI OLOGY	0	22, 934		0 0	13, 421	69.00	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	54, 769 0			32, 051 0		
72.00	07300 DRUGS CHARGED TO PATIENTS	0	15, 415			9, 021	•	
	OUTPATIENT SERVICE COST CENTERS							
90. 00 90. 01	09000 CLINIC 09001 SENIOR CARE	0	9, 556 0			5, 592 0		
	09002 GENERAL SURGERY	0	0			0		
90.03	09003 HARRI SON CRAWFORD HEALTHCARE	0	0			0		
90. 04 90. 05	09004 CORYDON MEDICAL ASSOCIATES 09005 ORTHOPEDIC SURGERY - DR KLINE	0	0	78, 00 <sup>°</sup> 100, 176		0		
90.06	09006 OBGYN - DR SAUER	0	0	30, 055	5 0	0	90.06	
90. 07 90. 08	09007 FIRST CAPITAL MEDICAL GROUP 09008 SOUTH HARRISON FAMILY MEDICINE	0	0	56, 893		0		
90.08 90.09	09009 PAIN MANAGEMENT	0	0	33, 67 <sup>-</sup> 22, 84 <sup>-</sup>		0		
90.10	09010 DERMATOLOGY	0	0	25, 08	7 0	0	90.10	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	82, 468	(	0 0	48, 260	91.00 92.00	
72.00	OTHER REIMBURSABLE COST CENTERS	<u>                                     </u>		<u> </u>	<u> </u>		72.00	
95.00	09500 AMBULANCE SERVICES	0	0	(	58, 866	0	95.00	
113 00	SPECIAL PURPOSE COST CENTERS						113.00	
118.00		0	1, 606, 147	447, 07 <sup>-</sup>	1 58, 866	939, 906		
100.00	NONREI MBURSABLE COST CENTERS		10 047			F 007	100.00	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	10, 247 83, 185				190.00 192.00	
194.00	07950 MARKETI NG	0	0		0	0	194.00	
	07951 PHYSI CI AN BILLING	0	6, 287				194.01	
194.02 200.00	07952 MOB Cross Foot Adjustments	0	0	173, 322		0	194.02 200.00	
201.00	Negative Cost Centers		0		0 0		201.00	
202.00	TOTAL (sum lines 118 through 201)	0	1, 705, 866	620, 393	3 58, 866	998, 261	202.00	

ALLOCA	Financial Systems TION OF CAPITAL RELATED COSTS	HARRI SON COUNT	Provider CC	F	eriod: rom 01/01/2021 o 12/31/2021	u of Form CMS-2 Worksheet B Part II Date/Time Pre 5/31/2022 11:	pared
		CAPI TAL					
	Cost Center Description	AMB EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI V E & GENERAL	ADMI TTI NG	
		2.01	2A	4. 00	5. 01	5. 02	
	GENERAL SERVICE COST CENTERS	1 1			1		
1. 01 1. 02 2. 00 2. 01 4. 00 5. 01 5. 02 5. 03 7. 00 3. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB 00102 AMB DEPR 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL 00570 ADMINISTRATIVE & GENERAL 00580 CASHIERING/ACCOUNTS RECEIVABLE 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 0 0 0 0	3, 987 404, 565 0 312, 678 18, 257	3, 987 242 74 57 38 38	404, 807 6, 027 11, 115 16, 310 2, 386	6, 101 0 0 0	7. C 8. C
	00900 HOUSEKEEPI NG	0	39, 105	76		0	9.0
	01000 DI ETARY 01100 CAFETERI A	0	113, 787 56, 843	28 38		0	10. 0
	01300 NURSI NG ADMI NI STRATI ON	0	9, 567	100		0	13.0
	01400 CENTRAL SERVICES & SUPPLY	0	0	31		0	14. C
	01600 MEDICAL RECORDS & LIBRARY	0	63, 481	93		0	16.0
7.00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	3, 827	43	3, 446	0	17. C
30.00	03000 ADULTS & PEDIATRICS	0	432, 177	525	48, 749	324	30.0
	03100 I NTENSI VE CARE UNI T	0	57, 741	69		55	
	04300 NURSERY	0	11, 959	24	1, 584	58	43. C
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	353, 219	145	16, 351	503	50. C
	05300 ANESTHESI OLOGY	0	0	0		105	
	05400 RADI OLOGY-DI AGNOSTI C	0	185, 060	154		1, 285	
		0	103, 088	120 0		927	60.0
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	21, 167 71, 613	47		83 107	65. C
	06700 OCCUPATI ONAL THERAPY	0	0	6		14	67.0
	06800 SPEECH PATHOLOGY	0	0	1		6	68. C
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	36, 355 86, 820	68 0		399 182	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	00, 820	0		104	
	07300 DRUGS CHARGED TO PATIENTS	0	24, 436	50		332	
	OUTPATIENT SERVICE COST CENTERS		45 440				1 00 0
	09000 CLINIC 09001 SENIOR CARE	0	15, 148 10, 849	4 12		8 12	90. C
	09002 GENERAL SURGERY	0	14, 466	117		3	
	09003 HARRI SON CRAWFORD HEALTHCARE	0	65, 477	83		6	
	09004 CORYDON MEDICAL ASSOCIATES	0	78, 001	75		21	
	09005 ORTHOPEDIC SURGERY - DR KLINE 09006 OBGYN - DR SAUER	0	100, 176 30, 055	181 77		25 4	90.0 90.0
	09007 FIRST CAPITAL MEDICAL GROUP	0	56, 893	123		11	90.0
0. 08	09008 SOUTH HARRISON FAMILY MEDICINE	0	33, 671	41	2, 025	2	90.0
	09009 PALN MANAGEMENT	0	22, 841	23		4	90.0
	09010 DERMATOLOGY 09100 EMERGENCY	0	25, 087 130, 728	68 261		17 1, 107	90. <sup>-</sup> 91. (
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0		27,171	1, 107	92.0
5.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	246, 438	305, 304	321	31, 914	397	95.
18. 00		246, 438	3, 298, 428	3, 418	341, 762	6, 101	113. ( 118. (
	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16, 244	0	138	0	190. (
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	131, 864	517			192. (
94.00	07950 MARKETI NG	0	0	0	0	0	194. (
	07951 PHYSICIAN BILLING	0	9, 966	52			194. (
	07952 MOB	0	173, 322	0	1, 468	0	194.0
00.00 01.00	Cross Foot Adjustments Negative Cost Centers	0	0	0	0	Ο	200. ( 201. (
	TOTAL (sum lines 118 through 201)	246, 438	3, 629, 824	3, 987	-		

Health Financial Systems	HARRI SON COUN	TY_HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Pre 5/31/2022 11:	epared: 29 am
Cost Center Description	CASHI ERI NG/AC COUNTS RECEI VABLE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	5.03	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS			1			1 1 00
1.00       00100       NEW CAP REL COSTS-BLDG & FLXT         1.01       00101       MOB         1.02       00102       AMB DEPR         2.00       00200       NEW CAP REL COSTS-MVBLE EQUI P         2.01       00201       AMB EQUI P         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         5.01       00590       ADMI NI STRATI VE & GENERAL         5.02       00570       ADMI NI STRATI VE & GENERAL         5.03       00580       CASHI ERI NG/ACCOUNTS RECEI VABLE         7.00       00700       OPERATI ON OF PLANT         8.00       00800       LAUNDRY & LI NEN SERVI CE         9.00       00900       HOUSEKEEPI NG         10.00       01100       CAFTERI A         13.00       01300       NURSI NG ADMI NI STRATI ON         14.00       01400       CENTRAL SERVI CES & SUPPLY         16.00       01600       MEDI CAL RECORDS & LI BRARY         17.00       01700       SOCI AL SERVI CE	11, 172 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	329, 026 3, 024 6, 477 18, 845 9, 414 1, 584 0 10, 514 634	23, 670 0 264 0 0 0 0 0	53, 458 3, 153 1, 575 265 0 1, 759	140, 355 0 0 0 0 0 0	11.00 13.00 14.00 16.00
	505	71 570	( 0(2	11.07/	110 ( 40	1 20 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	585 99	71, 579 9, 563			118, 640 21, 715	
43. 00 04300 NURSERY	104	1, 981			0	
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATING ROOM	909	58, 500			0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	190 2, 473	0 30, 650		-	0	
60. 00 06000 LABORATORY	1, 674	16, 109			0	
65. 00 06500 RESPIRATORY THERAPY	150	3, 506			0	
66. 00 06600 PHYSI CAL THERAPY	193	11, 860			0	
67.00 06700 OCCUPATI ONAL THERAPY	25	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	11	0	, °		0	
69. 00 06900 ELECTROCARDI OLOGY	721	6, 021			0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	329 188	14, 379 0			0	
73.00 07300 DRUGS CHARGED TO PATIENT	599	4, 047			0	
OUTPATIENT SERVICE COST CENTERS	577	4,047	0	011	0	/ 0.00
90. 00 09000 CLI NI C	14	2, 509	30	420	0	90.00
90. 01 09001 SENI OR CARE	22	0			0	
90. 02 09002 GENERAL SURGERY	5	0	25	0	0	
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE 90. 04 09004 CORYDON MEDI CAL ASSOCI ATES	11 38	0	1	0	0	
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE	45	0	10		0	
90. 06 09006 0BGYN - DR SAUER	8	0		-	0	
90. 07 09007 FIRST CAPITAL MEDICAL GROUP	19	0	36	0	0	
90. 08 09008 SOUTH HARRISON FAMILY MEDICINE	4	0	11	0	0	
90. 09 09009 PALN MANAGEMENT	8	0	31	0	0	
90. 10 09010 DERMATOLOGY 91. 00 09100 EMERGENCY	31 2, 000	21, 651	126 6, 601	3, 622	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,000	21,031	0,001	5,022	0	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 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	11, 172	302, 847	23, 196	49, 078	140, 355	113.00 118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 690	0	450	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	21, 839	474			192.00
194. 00 07950 MARKETI NG	0	0	0	0		194.00
194. 01 07951 PHYSI CLAN BILLING 194. 02 07952 M0B	0	1,650	0	276 0		194.01 194.02
200.00 Cross Foot Adjustments	0	U		0	0	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		
	·			·		

	Financial Systems TION OF CAPITAL RELATED COSTS	HARRI SON COUN	TY HOSPITAL Provider CC		eriod:	u of Form CMS-2 Worksheet B	2552-10
				T		Part II Date/Time Pre 5/31/2022 11:	pared: 29 am
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		11.00	13.00	14.00	16.00	17.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02 2. 00 2. 01	00101 MOB 00102 AMB DEPR 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP						1.01 1.02 2.00 2.01
4.00 5.01 5.02 5.03 7.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00700 OPERATION OF PLANT						4.00 5.01 5.02 5.03 7.00
8.00 9.00 10.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY						8.00 9.00 10.00
11.00	01100 CAFETERIA (01300) NURSI NG ADMI NI STRATI ON	71, 783 2, 105					10.00 11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 423	0	10, 183			14.00
	01600 MEDI CAL RECORDS & LIBRARY 01700 SOCI AL SERVI CE I NPATI ENT ROUTI NE SERVI CE COST CENTERS	3, 440 805	0	26		8, 864	16.00 17.00
30.00	03000 ADULTS & PEDIATRICS	16, 541	10, 420	306	4, 633	6, 130	30.00
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	1, 947 757	1, 226 477	63 0		1, 153 1, 581	31.00 43.00
101 00	ANCILLARY SERVICE COST CENTERS	,,,,				1,001	
50.00 53.00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	5, 256 0		394 22		0	50.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 208	-	224		0	54.00
60.00	06000 LABORATORY	3, 565	0	2, 137		0	60.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 1, 092	0	50 12		0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	141	0	0	201	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	23 1, 752		0 59		0	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		3, 862		0	71.00
	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	0 795		2, 036 29		0	72.00
73.00	OUTPATIENT SERVICE COST CENTERS	/95	0	29	4, 743	0	73.00
	09000 CLI NI C	100		1		0	•
90. 01 90. 02	09001 SENI OR CARE 09002 GENERAL SURGERY	272 1, 308		3 17		0	90.01 90.02
90.02 90.03	09002 GENERAL SURGERT	2, 033		33		0	90.02
	09004 CORYDON MEDICAL ASSOCIATES	1, 566		30		0	90.04
	09005 ORTHOPEDIC SURGERY - DR KLINE 09006 OBGYN - DR SAUER	2, 237 712		33 86		0	
90.00 90.07	09007 FIRST CAPITAL MEDICAL GROUP	2, 985		99		0	•
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	907		69		0	90.08
	09009 PAI N MANAGEMENT 09010 DERMATOLOGY	109 843		1 28	63 249	0	90.09 90.10
	09100 EMERGENCY	7, 807		222		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	338	5, 684	0	95.00
113.00	SPECIAL PURPOSE COST CENTERS						113.00
118.00		65, 729	21, 687	10, 183	88, 149	8, 864	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 MARKETING	3, 810 0		0	0		192.00 194.00
194.01	07951 PHYSI CLAN BILLING	2, 244	0	0	0	0	194.01
194.02 200.00	07952 MOB	0	0	0	0	0	194.02
200 00	Cross Foot Adjustments						200.00
200.00	Negative Cost Centers	0	0	0	0	0	201.00

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1331	Period: From 01/01/2021	Worksheet B Part II
				To 12/31/2021	Date/Time Prepared: 5/31/2022 11:29 am
Cost Center Description	Subtotal	Intern &	Total		575172022 11. 29 alli
		Residents Cost & Post			
		Stepdown			
	24.00	Adjustments 25.00	26.00		
GENERAL SERVICE COST CENTERS					
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 1.01 00101 MOB					1.00
1.02 00102 AMB DEPR					1.02
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2. 01 00201 AMB EQUIP					2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 01 00590 ADMI NI STRATI VE & GENERAL 5. 02 00570 ADMI TTI NG					5. 01 5. 02
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5.02
7. 00 00700 OPERATION OF PLANT					7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG					8.00 9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON					11.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE					16.00 17.00
INPATIENT ROUTINE SERVICE COST CENTERS					17.00
30.00 03000 ADULTS & PEDIATRICS	728, 647	0	728, 64		30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	105, 289 19, 682	0			31.00 43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	457, 286 1, 953	0	457, 28 1, 95		50.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	271, 383	0	271, 38		54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	165, 433	0	165, 43		60.00 65.00
66.00 06600 PHYSI CAL THERAPY	31, 306 92, 418	0	31, 30 92, 41		66.00
67.00 06700 OCCUPATI ONAL THERAPY	818	0	8		67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	198 59, 869	0	19 59, 80		68.00 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	INTS 126, 696	0	126, 69	96	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	11, 579 56, 672	0			72.00 73.00
OUTPATIENT SERVICE COST CENTERS	30, 072	0			/3.00
90. 00 09000 CLI NI C 90. 01 09001 SENI OR CARE	18, 824 13, 389	0	18, 82 13, 38		90.00 90.01
90. 02 09002 GENERAL SURGERY	18, 746	0			90.01
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE	71, 904	0	71, 90		90.03
90. 04 09004 CORYDON MEDICAL ASSOCIATES 90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE	83, 279 107, 093	0	83, 2 107, 0		90.04 90.05
90. 06 09006 OBGYN - DR SAUER	32, 890	0	32, 89	90	90.06
90. 07 09007 FIRST CAPITAL MEDICAL GROUP 90. 08 09008 SOUTH HARRISON FAMILY MEDICINE	68, 767 36, 760	0	68, 70 36, 70		90.07 90.08
90. 09 09009 PAIN MANAGEMENT	23, 294	0	23, 29	94	90.09
90. 10 09010 DERMATOLOGY 91. 00 09100 EMERGENCY	28, 613 218, 930	0	28, 6 218, 9		90. 10 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA		0	210, 9		91.00
OTHER REIMBURSABLE COST CENTERS	· · ·		24/ 0/		
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	346, 009	0	346, 00	ען	95.00
113.00 11300 INTEREST EXPENSE	117)		0 107 -		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through NONREIMBURSABLE COST CENTERS	117) 3, 197, 727	0	3, 197, 72	27	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTE		0	19, 52		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 MARKETI NG	218, 506	0	218, 50	06 0	192.00 194.00
194.0107951 PHYSICIAN BILLING	19, 279	0	19, 2		194.00
194. 02 07952 MOB	174, 790	0	174, 79	90	194.02
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0		0	200.00 201.00
202.00 TOTAL (sum lines 118 through 201)	3, 629, 824	0	3, 629, 82	24	202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	HARRI SON COUNT	Y HOSPITAL Provider CC		eri od:	u of Form CMS- Worksheet B-1	
				Fr To	com 01/01/2021 0 12/31/2021	Date/Time Pre	
			CAPI	TAL RELATED CO	STS	5/31/2022 11:	29 am
	Cost Center Description	NEW BLDG & FI XT (SQUARE FEET) 1.00	MOB (SQUARE FEET) 1.01	AMB DEPR (SQUARE FEET) 1.02	NEW MVBLE EQUI P (SQUARE FEET) 2. 00	AMB EQUIP (SQUARE FEET) 2. 01	
	GENERAL SERVICE COST CENTERS						
1.00 1.01 1.02 2.00 2.01 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB 00102 AMB DEPR 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	135, 674 0 0 200	32, 594 0 0	11, 032	135, 674 0 200	11, 032 0	
5. 01 5. 02 5. 03	00590 ADMI NI STRATI VE & GENERAL 00570 ADMI TI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	20, 111 0 0	196 0 0	0 0 0	20, 111 0 0	0 0 0	5. 01 5. 02
7.00 8.00 9.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	15, 688 916 1, 962	0 0 0	0 0 0	15, 688 916 1, 962	0 0 0	8.00 9.00
14.00	01000 DI ETARY 01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01600 MEDI CAL RECORDS & LI BRARY	5, 709 2, 852 480 0 3, 185	0 0 0 0	0 0 0 0	5, 709 2, 852 480 0 3, 185	0 0 0 0 0	11.00 13.00 14.00
17.00	01700 SOCI AL SERVI CE I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	21, 684	0	0	21, 684	0	17.00
31.00	03100 I NTENSI VE CARE UNI T 04300 I NURSERY ANCI LLARY SERVI CE COST CENTERS	2, 897 600	0 0	0	2, 897 600	0	31.00
	05000 OPERATING ROOM	17, 722	0	0	17, 722	0	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 9, 285	0 0	0 0	0 9, 285	0 0	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	4, 880 1, 062	306 0	0	4, 880 1, 062	0	
66. 00	06600 PHYSI CAL THERAPY	3, 593	0	0	3, 593	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 1, 824	0	0 0	0 1, 824	0	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	4, 356	0	0	4, 356	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	0 1, 226	0	0	0 1, 226	0	
	OUTPATIENT SERVICE COST CENTERS		-	-			
	09000 CLINIC 09001 SENIOR CARE	760 0	0 570	0	760 0	0 0	
90.02	09002 GENERAL SURGERY	0	760	0	0	0	90.02
90. 03 90. 04	09003 HARRI SON CRAWFORD HEALTHCARE 09004 CORYDON MEDI CAL ASSOCI ATES	0	3, 440 4, 098	0	0	0	1
90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	0	5, 263	0	0	0	90.05
	09006 OBGYN - DR SAUER 09007 FIRST CAPITAL MEDICAL GROUP	0	1, 579 2, 989	0	0	0	
90.08	09008 SOUTH HARRISON FAMILY MEDICINE	0	1, 769	0	0	0	
90. 09 90. 10	09009 PAIN MANAGEMENT 09010 DERMATOLOGY	0	1,200	0	0	0 0	
	09100 EMERGENCY	6, 559	1, 318 0	0	6, 559	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	11, 032	0	11, 032	95.00
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	127, 743	23, 488	11, 032	127, 743	11 022	113.00 118.00
	NONREI MBURSABLE COST CENTERS			-			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	815 6, 616	0	0	815 6, 616		190.00 192.00
194.00	07950 MARKETI NG	0	0	0	0	0	194.00
	07951 PHYSICIAN BILLING	500	0	0	500		194.01
194.02 200.00	07952 MOB Cross Foot Adjustments	0	9, 106	0	0	0	194.02 200.00
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
203.00 204.00		12. 573271	19. 033963	5. 335932	7. 357791	22. 338470	203.00 204.00
205.00							205.00

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021	Worksheet B-1	l	
				To 12/31/2021	Date/Time Pre 5/31/2022 11:		
	CAPITAL RELATED COSTS						
Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUI P (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	

<sup>5/31/2022 11:29</sup> am

	Financial Systems LLOCATION - STATISTICAL BASIS	HARRI SON COUNT	Y HOSPITAL Provider CO		eriod:	u of Form CMS-2 Worksheet B-1	
				Fi To	com 01/01/2021 0 12/31/2021	Date/Time Pre 5/31/2022 11:	
	Cost Center Description	EMPLOYEE F BENEFITS DEPARTMENT (GROSS SALARIES) 4.00	Reconci I i ati o n 5A. 01	ADMI NI STRATI V E & GENERAL (ACCUM COST) 5. 01	ADMI TTI NG (GROSS CHARGES) 5. 02	CASHI ERI NG/AC COUNTS RECEI VABLE (GROSS CHARGES) 5. 03	29 מווו
	GENERAL SERVICE COST CENTERS	1.00	0/1. 01	0.01	0.02	0.00	
$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 2. \ 00 \\ 2. \ 01 \\ 4. \ 00 \\ 5. \ 01 \\ 5. \ 02 \\ 5. \ 03 \\ 7. \ 00 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 16. \ 00 \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB 00102 AMB DEPR 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMI NI STRATI VE & GENERAL 00570 ADMI NI STRATI VE & GENERAL 00570 OPERATION OF PLANT 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00700 OPERATION OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCIAL SERVI CE	27, 654, 641 1, 681, 232 516, 455 395, 285 264, 804 23, 289 529, 169 193, 845 262, 369 691, 198 218, 416 645, 573 299, 647	-5, 612, 393 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	47, 793, 572 711, 618 1, 312, 281 1, 925, 579 281, 720 920, 884 505, 019 462, 033 952, 331 1, 030, 529 1, 043, 252 406, 809	171, 028, 988 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	171, 028, 988 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 1.01 1.02 2.00 2.01 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00 11.00 13.00 14.00 14.00 17.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	3, 611, 496	0	5, 755, 472	8, 995, 848	8, 995, 848	30.00
	03100 I NTENSI VE CARE UNI T	477, 684	0	704, 694 187_018	1, 527, 626 1, 603, 986	1, 527, 626 1, 603, 986	
50.00	04300 NURSERY ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	166, 443	0	187, 018 1, 930, 428	1, 603, 986	1, 603, 986 13, 979, 477	43.00 50.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 1, 067, 108	0	15, 804 2, 244, 880	2, 916, 787 37, 225, 668	2, 916, 787 37, 225, 668	53.00 54.00
60.00	06000 LABORATORY	834, 370	0	2, 580, 713	25, 746, 371	25, 746, 371	60.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 323, 275	0	540, 323 470, 332	2, 302, 938 2, 962, 985	2, 302, 938 2, 962, 985	
	06700 OCCUPATI ONAL THERAPY	41, 296	0	50, 934	390, 488	390, 488	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	6, 796 475, 303	0 0	8, 429 711, 679	167, 360 11, 093, 941	167, 360 11, 093, 941	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1, 902, 220 916, 554	5, 059, 510 2, 888, 603	5, 059, 510 2, 888, 603	
73.00	07300 DRUGS CHARGED TO PATIENTS	0 349, 315	0	2, 475, 105	2, 888, 803 9, 209, 486	9, 209, 486	
	OUTPATIENT SERVICE COST CENTERS	24, 483	0	49, 069	214, 760	214, 760	90.00
90. 01	09001 SENI OR CARE	84, 871	0	220, 479	344, 980	344, 980	90.01
	09002 GENERAL SURGERY 09003 HARRI SON CRAWFORD HEALTHCARE	809, 036 577, 979	0	326, 913 492, 910	70, 234 164, 263	70, 234 164, 263	
	09004 CORYDON MEDICAL ASSOCIATES	518, 135	0	382, 409	589, 989	589, 989	
	09005 ORTHOPEDIC SURGERY - DR KLINE 09006 OBGYN - DR SAUER	1, 259, 659 531, 396	0	476, 099 216, 199	686, 388 124, 454	686, 388 124, 454	90.05 90.06
	09000 BGTN - DR SAUER 09007 FIRST CAPITAL MEDICAL GROUP	856, 664	0	210, 199 997, 458	297, 959	297, 959	
	09008 SOUTH HARRI SON FAMILY MEDICINE	286, 311	0	239, 039	57, 839	57, 839	
	09009 PAIN MANAGEMENT 09010 DERMATOLOGY	159, 479 475, 298	0	25, 265 255, 483	121, 661 484, 459	121, 661 484, 459	90.09 90.10
91.00	09100 EMERGENCY	1, 812, 611	0	2, 853, 712	30, 763, 872	30, 763, 872	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	09500 AMBULANCE SERVICES	2, 225, 732	0	3, 767, 836	11, 037, 056	11, 037, 056	95.00
	SPECIAL PURPOSE COST CENTERS						112 00
118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	23, 702, 383	-5, 612, 393	40, 349, 511	171, 028, 988	171, 028, 988	113.00 118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFICES	0 3, 592, 102	0 0	16, 244 6, 653, 414	0 0		190. 00 192. 00
194.00	07950 MARKETI NG	0	0	0	0	0	194.00
	07951 PHYSICIAN BILLING 07952 MOB	360, 156 0	0	601, 081 173, 322	0		194.01 194.02
200.00	Cross Foot Adjustments	5	0	1,0,022	0	0	200.00
201.00	Negative Cost Centers Cost to be allocated (per What P	1 404 000		F 410 200	70F 100	1 464 202	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 404, 888		5, 612, 393	795, 183	1, 466, 382	
203.00 204.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	0. 050801 3, 987		0. 117430 404, 807	0. 004649 6, 101	0. 008574 11, 172	204.00
205.00	,	0. 000144		0.008470	0. 000036	0. 000065	205 00

Health Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/31/2022 11:	pared: 29 am
Cost Center Description	EMPLOYEE	Reconciliatio			CASHI ERI NG/AC	
	BENEFITS	n	E & GENERAL	(GROSS	COUNTS	
	DEPARTMENT		(ACCUM COST)	CHARGES)	RECEI VABLE	
	(GROSS				(GROSS	
	SALARI ES)				CHARGES)	
	4.00	5A. 01	5.01	5.02	5.03	
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

<sup>5/31/2022 11:29</sup> am

	Financial Systems LOCATION - STATISTICAL BASIS	HARRI SON COUN	Provider C		Period:	u of Form CMS-: Worksheet B-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/31/2022 11:	pared: 29 am
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (TOTAL PATI ENT DAYS)	CAFETERI A (HOURS OF SERVI CE)	
	CENEDAL SEDVICE COST CENTEDS	7.00	8.00	9.00	10.00	11.00	
$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 2.\ 00\\ 2.\ 01\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB 00102 AMB DEPR 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL 00570 ADMINISTRATIVE & GENERAL 00570 ADMINISTRATIVE & GENERAL 00580 CASHIERING/ACCOUNTS RECEIVABLE 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	99, 675 916 1, 962 5, 709 2, 852 480 0 3, 185 192	203, 645 0 2, 273	96, 797 5, 709 2, 852 480 C	3, 639 0 0 0 0 0 0 0 0	31, 674 929 628 1, 518 355	13.00 14.00 16.00
30.00 31.00 43.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY	21, 684 2, 897 600	52, 152 28, 409 0	2, 897	563	7, 300 859 334	31.00
$\begin{array}{c} 50.\ 00\\ 53.\ 00\\ 54.\ 00\\ 60.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ \end{array}$	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07200 DRUGS CHARGED TO PATI ENTS 07200 DRUGS CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	17, 722 0 9, 285 4, 880 1, 062 3, 593 0 0 1, 824 4, 356 0 1, 226	14, 734 0 25, 345 0 0 0 0 0 5, 531 0 0 0 0	0 9, 285 4, 880 1, 062 3, 593 0 0 0 1, 824 4, 356 0		2, 319 0 2, 298 1, 573 0 482 62 10 773 0 0 351	53.00 54.00 60.00 65.00 66.00 67.00 68.00 69.00 71.00 72.00
90.00 90.01 90.02 90.03 90.04 90.05 90.06 90.07 90.08 90.09 90.10 91.00 92.00	OUTPATI ENT SERVICE COST CENTERS 09000 CLINIC 09001 SENIOR CARE 09002 GENERAL SURGERY 09003 HARRISON CRAWFORD HEALTHCARE 09004 CORYDON MEDICAL ASSOCIATES 09005 ORTHOPEDIC SURGERY - DR KLINE 09006 OBGYN - DR SAUER 09006 OBGYN - DR SAUER 09007 FIRST CAPITAL MEDICAL GROUP 09008 SOUTH HARRISON FAMILY MEDICINE 09009 PAIN MANAGEMENT 09010 DERMATOLOGY 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	760 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23 216 8 42 90 458 307 92 270 1,080				90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 90. 09 90. 10
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	11, 474	C	0	0	95.00
113.00 118.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	91, 744	199, 570	88, 866	3, 639	29, 003	113. 00 118. 00
190.00 192.00 194.00 194.01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 MARKETING 07951 PHYSICIAN BILLING 07952 MOB Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	815 6, 616 0 500 0 2, 151, 700	4, 075 0 0 0	C 50C C		1, 681 0 990	190. 00 192. 00 194. 00 194. 01 194. 02 200. 00 201. 00 202. 00
203.00 204.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	21. 587158 329, 026				19. 240513 71, 783	203. 00 204. 00
205.00 206.00	Part II) Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated (per Wkst. B-2)	3. 300988	0. 116232	0. 552269	38. 569662	2. 266307	205. 00 206. 00

Health Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021	Worksheet B-1	
	To 1				Date/Time Prepared: 5/31/2022 11:29 am	
Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE	(TOTAL	(HOURS OF	
	(SQUARE	(POUNDS OF	FEET)	PATI ENT DAYS)	SERVI CE)	
	FEET)	LAUNDRY)				
	7.00	8.00	9.00	10.00	11.00	
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

	Financial Systems LLOCATION - STATISTICAL BASIS	HARRI SON COUN	TY HOSPITAL Provider CC		In Lie eriod: rom 01/01/2021	u of Form CMS-2552-10 Worksheet B-1
				T		Date/Time Prepared:
	Cost Center Description	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS) 13. 00	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14.00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00	SOCI AL SERVI CE (TOTAL PATI ENT DAYS) 17.00	5/31/2022 11: 29 am
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 2. \ 00 \\ 2. \ 01 \\ 4. \ 00 \\ 5. \ 01 \\ 5. \ 02 \\ 5. \ 03 \\ 7. \ 00 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 16. \ 00 \end{array}$	00101 MOB 00102 AMB DEPR 00200 NEW CAP REL COSTS-MVBLE EQUI P 00200 AMB EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00590 ADMI NI STRATI VE & GENERAL 00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	15, 194 0 0 0	4, 584, 743 11, 724 1, 487	171, 028, 988 0	4, 327	1. 01 1. 01 1. 02 2. 00 2. 01 4. 00 5. 01 5. 02 5. 03 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 13. 00 14. 00 14. 00 13. 00 14. 00 14. 00 13. 00 14. 00 17. 00 17
	INPATIENT ROUTINE SERVICE COST CENTERS	7.000		0.005.040		
31.00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T 04300 NURSERY	7, 300 859 334	137, 689 28, 255 161	8, 995, 848 1, 527, 626 1, 603, 986	2, 992 563 772	30. 00 31. 00 43. 00
50. 00 53. 00 54. 00 60. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 90. 00 90. 01	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS 07000 CLI NI C 09000 CLI NI C 09001 SENI OR CARE	2, 319 0 0 0 0 0 0 0 0 0 773 0 0 0 0 44 120	177, 479 9, 862 101, 033 962, 241 22, 306 5, 210 0 46 26, 345 1, 740, 048 916, 554 12, 973 402 1, 244	13, 979, 477 2, 916, 787 37, 225, 668 25, 746, 371 2, 302, 938 2, 962, 985 390, 488 167, 360 11, 093, 941 5, 059, 510 2, 888, 603 9, 209, 486 214, 760 344, 980		50.00 53.00 54.00 60.00 65.00 65.00 67.00 68.00 69.00 71.00 72.00 73.00 90.00 90.01
90.03 90.04 90.05 90.06 90.07 90.08 90.09 90.10 91.00 92.00	09002 GENERAL SURGERY 09003 HARRI SON CRAWFORD HEALTHCARE 09004 CORYDON MEDI CAL ASSOCI ATES 09005 ORTHOPEDI C SURGERY - DR KLI NE 09006 OBGYN - DR SAUER 09007 FI RST CAPI TAL MEDI CAL GROUP 09008 SOUTH HARRI SON FAMI LY MEDI CI NE 09009 PAI N MANAGEMENT 09010 DERMATOLOGY 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	0 0 0 0 0 0 0 0 3,445	7, 557 14, 818 13, 342 14, 988 38, 562 44, 408 30, 944 563 12, 602 99, 913	70, 234 164, 263 589, 989 686, 388 124, 454 297, 959 57, 839 121, 661 484, 459 30, 763, 872		90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 90. 10 91. 00 92. 00
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	151, 987	11, 037, 056	0	95.00
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	15, 194	4, 584, 743	171, 028, 988	4, 327	113. 00 118. 00
192.00 194.00 194.01	Negative Cost Centers Cost to be allocated (per Wkst. B,	0 0 0 0 1, 097, 712	0 0 0 0 1, 163, 627	0 0 0 0 1, 301, 951	0 0 0 0 468, 058	190.00 192.00 194.00 194.01 194.01 194.02 200.00 201.00 202.00
203. 00 204. 00	Cost to be allocated (per Wkst. B,	72. 246413 21, 687	0. 253804 10, 183	0. 007612 88, 149	108. 171481 8, 864	203. 00 204. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part  II)	1. 427340	0. 002221	0. 000515	2. 048532	205.00

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/31/2022 11:	epared: 29 am
Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	SOCI AL		
	ADMI NI STRATI O	SERVICES &	RECORDS &	SERVI CE		
	N	SUPPLY	LI BRARY	(TOTAL		
	(DI RECT	(COSTED	(GROSS	PATI ENT DAYS)		
	NRSING HRS)	REQUIS.)	CHARGES)			
	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

<sup>5/31/2022 11:29</sup> am

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	HARRI SON COUN	Provi der C	CN. 1E 1001			<u>f Form CMS-2552-10</u> orksheet C	
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	UN: 15-1331	Period: From 01/01/2021	Part I		
				To 12/31/2021	Date/Time Pre	pared:	
					5/31/2022 11:	29 am	
		Title	XVIII	Hospi tal	Cost		
				Costs			
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs		
	(from Wkst.	Adj .		Di sal I owance			
	B, Part I,						
	col. 26)	0.00	0.00	1.00	F 00		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.07/ 750	1	0.07/ 7	- 0			
30. 00 03000 ADULTS & PEDIATRICS	9, 076, 752		9, 076, 75		0		
31. 00 03100 INTENSIVE CARE UNIT	1, 223, 940		1, 223, 94		0		
43. 00 04300 NURSERY	376, 098		376, 09	98 0	0	43.00	
ANCI LLARY SERVI CE COST CENTERS	0.000 514	1	0.000 5			1 50 00	
50. 00 05000 OPERATING ROOM	3, 308, 511		3, 308, 5		0		
53. 00 05300 ANESTHESI OLOGY	80, 935		80, 93		0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 698, 923		3, 698, 92		0		
	3, 854, 035		3, 854, 03		0		
65. 00 06500 RESPIRATORY THERAPY	692, 096	0			0		
66. 00 06600 PHYSI CAL THERAPY	715, 224	0	715, 22		0		
67. 00 06700 OCCUPATIONAL THERAPY	66, 243		66, 24		0		
68. 00 06800 SPEECH PATHOLOGY	13, 110		13, 11		0		
69. 00 06900 ELECTROCARDI OLOGY	1, 172, 449		1, 172, 44		0		
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	2, 814, 892		2, 814, 89		0		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	1, 316, 994		1, 316, 99		0		
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	3, 007, 719		3,007,71	19 0	0	73.00	
	00.440		00.44	58 0	0	90.00	
90. 00  09000  CLINIC 90. 01  09001  SENIOR CARE	88, 668		88,66		0		
90. 02 09002 GENERAL SURGERY	264, 891		264, 89	-	0		
90. 02 09002 GENERAL SURGERY 90. 03 09003 HARRI SON CRAWFORD HEALTHCARE	380, 141 575, 247		380, 14 575, 24		0		
90. 04 09004 CORYDON MEDICAL ASSOCIATES					0		
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE	456, 358 569, 250		456, 35 569, 25		0		
90. 06 09006 0BGYN - DR SAUER	260, 761		260, 76		0		
90. 07 09007 FIRST CAPITAL MEDICAL GROUP					0		
90. 07 09007 FIRST CAPITAL MEDICAL GROUP 90. 08 09008 SOUTH HARRISON FAMILY MEDICINE	1, 157, 912 284, 015		1, 157, 9 <sup>-</sup> 284, 0 <sup>-</sup>		0		
90. 09 09008 SOUTH HARRISON FAMILY MEDICINE 90. 09 09009 PAIN MANAGEMENT					0		
90. 10 09009 PATN MANAGEMENT 90. 10 09010 DERMATOLOGY	32, 278 307, 707		32, 27 307, 70		0		
91. 00 09100 EMERGENCY	4, 477, 847		4, 477, 84		0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0		
	2, 136, 631		2, 136, 63	51	0	92.00	
95.00 OTHER REIMBURSABLE COST CENTERS 95.00 O9500 AMBULANCE SERVICES	4, 497, 676		4, 497, 67	76 0	0	95.00	
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	4, 497, 676		4,497,6		0	1 95.00	
113. 00 11300 I NTEREST EXPENSE			1			113.00	
	44 007 202		44 007 20	03 0	0		
200.00Subtotal (see instructions)201.00Less Observation Beds	46, 907, 303	0				200.00	
	2, 136, 631	о	2, 136, 63			201.00	
202.00  Total (see instructions)	44, 770, 672	I 0	44, 770, 67	72 0	0	202.0	

	Financial Systems	HARRI SON COUNT				u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-1331	Peri od:	Worksheet C	
					From 01/01/2021 To 12/31/2021	Part     Date/Time Pre	narad
					10 12/31/2021	5/31/2022 11:	29 am
			Title	XVIII	Hospi tal	Cost	27 am
		Charges			iloopi tui		
	Cost Center Description	Inpatient	Outpatient	Total (col	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	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		7,023,58	38		1 30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 527, 626		1, 527, 62			31.00
43.00	04300 NURSERY	1, 603, 986		1,603,98			43.00
	ANCI LLARY SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	I				
50.00	05000 OPERATI NG ROOM	2, 710, 785	11, 268, 692	13, 979, 47	0. 236669	0.00000	50.00
53.00	05300 ANESTHESI OLOGY	900, 124	2,016,663	2, 916, 78		0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	976, 030	36, 249, 638	37, 225, 66		0.000000	
60.00	06000 LABORATORY	3, 416, 735	22, 329, 636	25, 746, 37		0.000000	
65.00	06500 RESPIRATORY THERAPY	1, 593, 109	709, 829	2, 302, 93		0.000000	
66.00	06600 PHYSI CAL THERAPY	419, 494	2, 543, 491	2, 962, 98		0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	206, 599	183, 889	390, 48		0.000000	
68.00	06800 SPEECH PATHOLOGY	69,040	98, 320	167, 36		0.000000	•
69.00	06900 ELECTROCARDI OLOGY	518, 710	10, 575, 231	11, 093, 94		0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 543, 363	3, 516, 147	5, 059, 5		0.000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	919, 375	1, 969, 228	2, 888, 60		0.000000	
	07300 DRUGS CHARGED TO PATIENTS	2, 661, 279	6, 548, 207	9, 209, 48		0.000000	
75.00	OUTPATIENT SERVICE COST CENTERS	2,001,277	0, 340, 207	7, 207, 40	0. 320307	0.000000	/ 3.00
90.00	09000 CLINIC	121	214, 639	214, 76	0. 412870	0.000000	90.00
90.01	09001 SENI OR CARE	0	344, 980	344, 98		0.000000	90.01
90.02	09002 GENERAL SURGERY	0	70, 234	70, 23		0.000000	
90.03	09003 HARRI SON CRAWFORD HEALTHCARE	0	164, 263	164, 26		0.000000	
90.03	09004 CORYDON MEDICAL ASSOCIATES	0	589, 989	589, 98		0.000000	
90.04 90.05	09005 ORTHOPEDIC SURGERY - DR KLINE	24	686, 364	686, 38		0.000000	
90.05 90.06	09006 OBGYN - DR SAUER	0	124, 454	124, 45		0.000000	
90.00 90.07	09007 FIRST CAPITAL MEDICAL GROUP	0	297, 959	297, 95		0.000000	
90.07	09008 SOUTH HARRISON FAMILY MEDICINE	0	57,839	57, 83		0.000000	
90.08 90.09	09009 PALN MANAGEMENT	0	121, 661	121, 66		0.000000	•
90.09 90.10	09010 DERMATOLOGY	0	484, 459	484, 45		0.000000	•
90. 10 91. 00	09100 EMERGENCY	469, 367	484, 459 30, 294, 505	484, 45 30, 763, 87		0.000000	•
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	469, 367 13, 740	1, 958, 520	30, 763, 8 1, 972, 26		0.000000	•
92.00	OTHER REIMBURSABLE COST CENTERS	13,740	1, 936, 320	1, 972, 20	1.003341	0.000000	92.00
95.00	09500 AMBULANCE SERVICES	0	11,037,056	11, 037, 05	0. 407507	0.000000	95.00
90.00	SPECIAL PURPOSE COST CENTERS	0	11, 037, 056	11, 037, 05	0.407507	0.000000	95.00
112 00	11300 INTEREST EXPENSE	1					112 00
200.00		24 572 005	144 455 000	171 020 00	00		113.00 200.00
200.00		26, 573, 095	144, 455, 893	171, 028, 98			200.00
201.00			144, 455, 893	171, 028, 98			201.00
202.00	Total (see instructions)	26, 573, 095					

Heal th Finar	ncial Systems	HARRI SON COUNTY	HOSPI TAL	In Lieu	ı of Form CMS-2552-1
COMPUTATION	OF RATIO OF COSTS TO CHARGES		Provi der 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	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
	·	Ratio			
		11.00			
I NPAT	IENT ROUTINE SERVICE COST CENTERS			·	
30.00 03000	ADULTS & PEDIATRICS				30.0
31.00 03100	INTENSIVE CARE UNIT				31.0
	NURSERY				43.0
	LARY SERVICE COST CENTERS				
	OPERATING ROOM	0.000000			50.0
	ANESTHESI OLOGY	0. 000000			53.0
	RADI OLOGY-DI AGNOSTI C	0. 000000			54.0
	LABORATORY	0. 000000			60.0
	RESPIRATORY THERAPY	0.000000			65.0
	PHYSICAL THERAPY				66.0
		0.000000			
	OCCUPATIONAL THERAPY	0.000000			67.0
	SPEECH PATHOLOGY	0. 000000			68.0
	ELECTROCARDI OLOGY	0. 000000			69.0
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.0
	IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.0
	DRUGS CHARGED TO PATIENTS	0. 000000			73.0
OUTPA	TIENT SERVICE COST CENTERS				
	CLINIC	0. 000000			90.0
90.01 09001	SENI OR CARE	0. 000000			90.0
90.02 09002	GENERAL SURGERY	0. 000000			90.0
90.03 09003	HARRI SON CRAWFORD HEALTHCARE	0. 000000			90.0
90.04 09004	CORYDON MEDICAL ASSOCIATES	0. 000000			90.0
	ORTHOPEDIC SURGERY - DR KLINE	0.000000			90.0
	OBGYN - DR SAUER	0. 000000			90.0
	FIRST CAPITAL MEDICAL GROUP	0. 000000			90.0
	SOUTH HARRI SON FAMILY MEDICINE	0.000000			90.0
	PALN MANAGEMENT	0.000000			90.0
	DERMATOLOGY	0.000000			90.0
	EMERGENCY	0.000000			91.0
	OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.0
	REIMBURSABLE COST CENTERS	0.00005-			
	AMBULANCE SERVICES	0. 000000			95.0
	AL PURPOSE COST CENTERS				
	INTEREST EXPENSE				113.0
200.00	Subtotal (see instructions)				200. 0
201.00	Less Observation Beds				201.0
202.00	Total (see instructions)				202.0

Health Financia	al Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF	RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1331	Peri od:	Worksheet C	
					From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 5/31/2022 11:	epared:
			Ti +1	e XIX	Hospi tal	Cost	29 dili
					Costs	0031	
Co	st Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
00.	st center bescription	(from Wkst.	Adj.		Di sal I owance	10101 00313	
		B, Part I,	naj.		Di Sai i Owanee		
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
I NPATI EN	IT ROUTINE SERVICE COST CENTERS		2100	0.00		0.00	
	ULTS & PEDIATRICS	9, 076, 752		9, 076, 75	52 0	9, 076, 752	30.00
	TENSIVE CARE UNIT	1, 223, 940		1, 223, 94			
43.00 04300 NU		376, 098		376, 09			1
	RY SERVICE COST CENTERS				-		
	ERATING ROOM	3, 308, 511		3, 308, 51	1 0	3, 308, 511	50.00
	ESTHESI OLOGY	80, 935		80, 93			
	DI OLOGY-DI AGNOSTI C	3, 698, 923		3, 698, 92		3, 698, 923	
60.00 06000 LA		3, 854, 035		3, 854, 03		3, 854, 035	
	SPI RATORY THERAPY	692,096				692,096	
	YSI CAL THERAPY	715, 224		715, 22		715, 224	
	CUPATIONAL THERAPY	66, 243		66, 24		66, 243	
	EECH PATHOLOGY	13, 110		13, 11		13, 110	1
	ECTROCARDI OLOGY	1, 172, 449		1, 172, 44		1, 172, 449	1
	DICAL SUPPLIES CHARGED TO PATIENTS	2, 814, 892		2, 814, 89			1
	IPL. DEV. CHARGED TO PATIENT	1, 316, 994		1, 316, 99		1, 316, 994	
	UGS CHARGED TO PATIENTS	3,007,719		3, 007, 71			
	ENT SERVICE COST CENTERS	0,00,111		0,001,11	,	0/00//////	10100
90.00 09000 CL		88, 668		88, 66	0 8	88, 668	90.00
	NIOR CARE	264, 891		264, 89			1
	NERAL SURGERY	380, 141		380, 14		380, 141	1
	RRISON CRAWFORD HEALTHCARE	575, 247		575, 24		575, 247	1
	RYDON MEDICAL ASSOCIATES	456, 358		456, 35		456, 358	
	THOPEDIC SURGERY - DR KLINE	569, 250		569, 25		569, 250	
	IGYN - DR SAUER	260, 761		260, 76		260, 761	
	RST CAPITAL MEDICAL GROUP	1, 157, 912		1, 157, 91		1, 157, 912	
	UTH HARRISON FAMILY MEDICINE	284, 015		284, 01		284, 015	
	IN MANAGEMENT	32, 278		32, 27		32, 278	
	RMATOLOGY	307, 707		307, 70		307, 707	
91.00 09100 EM		4, 477, 847		4, 477, 84		4, 477, 847	
	SERVATION BEDS (NON-DISTINCT PART)	2, 136, 631		2, 136, 63		2, 136, 631	1
	IMBURSABLE COST CENTERS	2,100,001		2,100,00		2,100,001	72.00
	BULANCE SERVICES	4, 497, 676		4, 497, 67	6 0	4, 497, 676	95.00
	PURPOSE COST CENTERS	., ., ., ., ., .,	I	., ., ,, ,, ,, ,,	- 0	.,, 070	
113.00 11300 I N							113.00
	btotal (see instructions)	46, 907, 303	l o	46, 907, 30	03 0	46, 907, 303	1
	ss Observation Beds	2, 136, 631	Ĭ	2, 136, 63		2, 136, 631	1
	tal (see instructions)	44, 770, 672	c c				
10		1 1.1, 1.0, 012		1,	-1 0		- 52.00

	Financial Systems	HARRI SON COUNT				u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-1331	Peri od:	Worksheet C	
					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	narod
					10 12/31/2021	5/31/2022 11:	29 am
			Title	e XIX	Hospi tal	Cost	27 um
		Charges			licopi tui		
	Cost Center Description	Inpatient	Outpati ent	Total (col	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	7,023,588		7,023,58	38		1 30. 00
	03100 I NTENSI VE CARE UNI T	1, 527, 626		1, 527, 62			31.00
	04300 NURSERY	1, 603, 986		1,603,98			43.00
	ANCI LLARY SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,					
	05000 OPERATING ROOM	2, 710, 785	11, 268, 692	13, 979, 47	0. 236669	0.00000	50.00
	05300 ANESTHESI OLOGY	900, 124	2,016,663	2, 916, 78		0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	976, 030	36, 249, 638	37, 225, 66		0.000000	
	06000 LABORATORY	3, 416, 735	22, 329, 636	25, 746, 37		0.000000	
	06500 RESPI RATORY THERAPY	1, 593, 109	709, 829	2, 302, 93		0.000000	
	06600 PHYSI CAL THERAPY	419, 494	2, 543, 491	2, 962, 98		0.000000	
	06700 OCCUPATI ONAL THERAPY	206, 599	183, 889	390, 48		0.000000	
	06800 SPEECH PATHOLOGY	69,040	98, 320	167, 36		0.000000	•
	06900 ELECTROCARDI OLOGY	518, 710	10, 575, 231	11, 093, 94		0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 543, 363	3, 516, 147	5, 059, 5		0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENT	919, 375	1, 969, 228	2, 888, 60		0.000000	
	07300 DRUGS CHARGED TO PATIENTS	2, 661, 279	6, 548, 207	9, 209, 48		0.000000	•
	OUTPATIENT SERVICE COST CENTERS	2,001,277	0, 340, 207	7,207,40	0. 320307	0.000000	/ 5.00
	09000 CLINIC	121	214, 639	214, 76	0. 412870	0.000000	90.00
	09001 SENI OR CARE	0	344, 980	344, 98		0.000000	90.01
	09002 GENERAL SURGERY	0	70, 234	70, 23		0.000000	
	09003 HARRI SON CRAWFORD HEALTHCARE	0	164, 263	164, 26		0.000000	
	09004 CORYDON MEDICAL ASSOCIATES	0	589, 989	589, 98		0.000000	
	09005 ORTHOPEDIC SURGERY - DR KLINE	24	686, 364	686, 38		0.000000	
	09006 OBGYN - DR SAUER	0	124, 454	124, 45		0.000000	
	09007 FIRST CAPITAL MEDICAL GROUP	0	297, 959	297, 95		0.000000	
	09008 SOUTH HARRISON FAMILY MEDICINE	0	57,839	57, 83		0.000000	
	09009 PALN MANAGEMENT	0	121, 661	121, 66		0.000000	•
	09009 PATN MANAGEMENT 09010 DERMATOLOGY	0	484, 459	484, 45		0.000000	•
	09100 EMERGENCY	469, 367	484, 459 30, 294, 505	484, 45 30, 763, 87		0.000000	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	469, 367 13, 740	1, 958, 520	30, 763, 8 1, 972, 26		0.000000	•
	OPED OF THE OF T	13, 740	1, 900, 520	1, 972, 20	1.003341	0.00000	92.00
	09500 AMBULANCE SERVICES	0	11,037,056	11, 037, 05	0. 407507	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS	0	11, 037, 056	11, 037, 08	0.407507	0.00000	95.00
	11300 INTEREST EXPENSE	1					112 00
200.00		24 572 005	144 455 000	171 020 00	00		113.00 200.00
200.00	Subtotal (see instructions) Less Observation Beds	26, 573, 095	144, 455, 893	171, 028, 98			200.00
201.00		26 572 005	144 455 000	171 000 00	20		201.00
		26, 573, 095	144, 455, 893	171, 028, 98	00		1202 00

lealth Financial Systems	HARRI SON COUNTY	HOSPI TAL	In Lieu	J of Form CMS-2552-1
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	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.0
31. 00 03100 INTENSIVE CARE UNIT				31.0
43. 00 04300 NURSERY				43. C
ANCI LLARY SERVI CE COST CENTERS	I			
50. 00 05000 OPERATING ROOM	0.000000			50.0
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0
	0. 000000			60. C
65. 00 06500 RESPIRATORY THERAPY	0.00000			65. C
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. C
57.00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. C
58.00 06800 SPEECH PATHOLOGY	0. 000000			68. C
59. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. C
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. C
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.0
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0.000000			90.0
90. 01 09001 SENI OR CARE	0. 000000			90.0
90. 02 09002 GENERAL SURGERY	0. 000000			90.0
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE	0. 000000			90.0
90. 04 09004 CORYDON MEDICAL ASSOCIATES	0. 000000			90.0
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE	0. 000000			90.0
90. 06 09006 0BGYN - DR SAUER	0. 000000			90.0
90. 07 09007 FIRST CAPITAL MEDICAL GROUP	0. 000000			90. C
90.08 09008 SOUTH HARRISON FAMILY MEDICINE	0.000000			90. C 90. C
90. 09 09009 PALN MANAGEMENT	0. 000000			90.0
90. 10 09010 DERMATOLOGY	0. 000000			90.1
91.00 09100 EMERGENCY	0. 000000			91. C
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.0
OTHER REIMBURSABLE COST CENTERS	<u>.</u>			
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.0
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113. C
	1			200. 0
200.00 Subtotal (see instructions)				200. 0
200.00Subtotal (see instructions)201.00Less Observation Beds				200.0

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C	CN: 15-1331	Period:	Worksheet D	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	narod
				10 12/31/2021	5/31/2022 11:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATING ROOM	457, 286				8, 683	
53. 00 05300 ANESTHESI OLOGY	1, 953				30	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	271, 383				1,853	54.00
60. 00 06000 LABORATORY	165, 433		0.00642		5, 760	
65. 00 06500 RESPI RATORY THERAPY	31, 306					65.00
66. 00 06600 PHYSI CAL THERAPY	92, 418					
67.00 06700 OCCUPATI ONAL THERAPY	818					67.00
68. 00 06800 SPEECH PATHOLOGY	198					68.00
69. 00 06900 ELECTROCARDI OLOGY	59, 869		0.00539			69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	126, 696					
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	11, 579					
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	56, 672	9, 209, 486	0.00615	819, 402	5, 043	73.00
	10.004	014 7/0	0.007/1	121	11	00.00
90. 00  09000  CLI NI C 90. 01  09001  SENI OR CARE	18, 824				0	90.00 90.01
90. 01 09001 SENTOR CARE 90. 02 09002 GENERAL SURGERY	13, 389				0	90.01
90. 02 09002 GENERAL SURGERY 90. 03 09003 HARRI SON CRAWFORD HEALTHCARE	18, 746 71, 904				0	90.02
90. 03 09003 HARRISON CRAWFORD HEALTHCARE 90. 04 09004 CORYDON MEDICAL ASSOCIATES	83, 279				0	90.03
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE	107, 093				4	90.04
90. 06 09006 0BGYN - DR SAUER	32, 890				4	90.05
90. 07 09007 FIRST CAPITAL MEDICAL GROUP	68, 767	297, 959			0	90.00
90. 08 09008 SOUTH HARRI SON FAMILY MEDICINE	36, 760				0	90.08
90. 09 09009 PAIN MANAGEMENT	23, 294	121, 661	0. 03555		0	90.08
90. 10 09010 DERMATOLOGY	28, 613				0	90.09
91. 00 09100 EMERGENCY	218, 930				89	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	171, 520				07	92.00
OTHER REIMBURSABLE COST CENTERS	171,020	1, 7, 2, 200	0.00070	0	0	12.00
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	
······			1	1		

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PAS				riod: om 01/01/2021 12/31/2021	Worksheet D Part IV Date/Time Pre 5/31/2022 11:	pared: 29 am
		Title	XVIII		Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	ŀ	Allied Health	Allied Health	
	Anestheti st	Program	Program	F	Post-Stepdown		
	Cost	Post-Stepdown			Adjustments		
		Adjustments			-		
	1.00	2A	2.00		3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			_				
50.00 05000 OPERATING ROOM	0	0		0	0	0	50.00
53.00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
60.00 06000 LABORATORY	0	0		0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	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	о	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	о	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC	0	0		0	0	0	90.00
90. 01 09001 SENI OR CARE	0	0		0	0	0	90.01
90. 02 09002 GENERAL SURGERY	0	0		0	0	0	90.02
90. 03 09003 HARRI SON 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 0BGYN - 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 HARRI SON FAMILY MEDICINE	0	0		0	0	0	90.08
90. 09 09009 PALN MANAGEMENT	0	0		0	0	0	90.09
90. 10 09010 DERMATOLOGY	0	0		0	o	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				- 1			
95. 00 09500 AMBULANCE SERVICES							95.00
200.00 Total (lines 50 through 199)	0	0		0	0	0	200.00
					- 1		

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERV HROUGH COSTS	ICE OTHER PAS	S Provider C	CN· 15-1331	Period:	Westeller D	
HROUGH COSTS					Worksheet D	
				From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre	narad
				10 12/31/2021	5/31/2022 11:	29 am
		Title	XVIII	Hospi tal	Cost	<u></u>
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
'	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	0	0		0 13, 979, 477	0. 000000	
3. 00 05300 ANESTHESI OLOGY	0	0		0 2, 916, 787	0.000000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 37, 225, 668	0.00000	
0. 00 06000 LABORATORY	0	0		0 25, 746, 371	0.00000	
5. 00 06500 RESPI RATORY THERAPY	0	0		0 2, 302, 938	0.00000	65.00
6. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 962, 985	0.00000	66.00
7.00 06700 OCCUPATI ONAL THERAPY	0	0		0 390, 488	0.000000	67.00
8.00 06800 SPEECH PATHOLOGY	0	0		0 167, 360	0.000000	68.00
9. 00 06900 ELECTROCARDI OLOGY	0	0		0 11, 093, 941	0.000000	69.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 5, 059, 510	0.000000	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 2, 888, 603	0.000000	72.00
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 9, 209, 486	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLINIC	0	0		0 214, 760	0.00000	90.00
0. 01 09001 SENI OR CARE	0	0		0 344, 980	0.00000	90.01
0. 02 09002 GENERAL SURGERY	0	0		0 70, 234	0.00000	90.02
0. 03 09003 HARRI SON CRAWFORD HEALTHCARE	0	0		0 164, 263	0.000000	90.03
0. 04 09004 CORYDON MEDICAL ASSOCIATES	0	0		0 589, 989	0.00000	90.04
0.05 09005 ORTHOPEDIC SURGERY - DR KLINE	0	0		0 686, 388	0.00000	
0.06 09006 0BGYN - DR SAUER	0	0		0 124, 454	0.00000	
0.07 09007 FIRST CAPITAL MEDICAL GROUP	0	0		0 297, 959	0.000000	90.07
0.08 09008 SOUTH HARRISON FAMILY MEDICINE	0	0		0 57,839	0.000000	90.08
0. 09 09009 PALN MANAGEMENT	0	0		0 121, 661	0.000000	90.09
0. 10 09010 DERMATOLOGY	0	0		0 484, 459	0. 000000	90.10
1.00 09100 EMERGENCY	0	0		0 30, 763, 872	0.000000	91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1, 972, 260	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						]
5. 00 09500 AMBULANCE SERVICES						95.00
00.00 Total (lines 50 through 199)	0	0		0 149, 836, 732		200.00

Health Financial Systems	HARRI SON COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-1331	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2021	Part IV	
				To 12/31/2021	Date/Time Pre 5/31/2022 11:	29 am
		Title	XVIII	Hospi tal	Cost	27 am
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
'	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷	5	Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	265, 461		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	44, 375		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	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 RESPI RATORY THERAPY	0. 000000	648, 255		0 0	0	65.00
66.00 06600 PHYSI CAL 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 ELECTROCARDI OLOGY	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 SENI OR 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 HARRI SON 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 0BGYN - 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 PALN 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)	1	4, 181, 773	1	0 0	0	200.00

Heal th Finar	ncial Systems	HARRI SON COUN	TY HOSPI TAL			u of Form CMS-	2552-10
APPORTI ONME	NT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-1331	Period: From 01/01/2021	Worksheet D Part V	
					To 12/31/2021	Date/Time Pre	pared:
						5/31/2022 11:	29 am
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Cost to	PPS	Charges Cost	Cost	Costs PPS Services	
	cost center bescription	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see		Servi ces Not	(see mst.)	
		Worksheet C.	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0. 236669		=/		0	50.00
	ANESTHESI OLOGY	0. 027748				0	53.00
	RADI OLOGY-DI AGNOSTI C	0. 099365		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	54.00
	LABORATORY	0. 149692	C			0	60.00
	RESPIRATORY THERAPY	0. 300527	0	317, 38		0	65.00
	PHYSICAL THERAPY	0. 241386		551, 49		0	66.00
	OCCUPATIONAL THERAPY	0. 169642		64, 24		0	67.00
	SPEECH PATHOLOGY	0. 078334		25, 80		0	68.00
	ELECTROCARDI OLOGY	0. 105684		0,00.,0		0	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 556357	0	020,0		0	71.00
	DRUGS CHARGED TO PATIENT	0. 455928 0. 326589				0	72.00 73.00
	ATIENT SERVICE COST CENTERS	0. 320369	(	3,003,04	40, 530	0	/3.00
90.00 09000		0. 412870	0	43, 20	0 00	0	90.00
	I SENI OR CARE	0. 767845				0	90.01
	2 GENERAL SURGERY	5. 412493		10, 6		0	90.02
	HARRISON CRAWFORD HEALTHCARE	3. 501988		3, 9:		0	90.03
	CORYDON MEDICAL ASSOCIATES	0. 773503				0	90.04
	ORTHOPEDIC SURGERY - DR KLINE	0. 829341	C	29, 34		0	90.05
90.06 09006	OBGYN - DR SAUER	2.095240	0	6,00		0	90.06
90.07 09007	FIRST CAPITAL MEDICAL GROUP	3. 886145	( C	7,28	5, 317	0	90.07
90. 08 09008	SOUTH HARRISON FAMILY MEDICINE	4. 910441	C	9,80	51 1, 523	0	90.08
90.09 09009	PAIN MANAGEMENT	0. 265311	C	1, 80	50 0	0	90.09
	DERMATOLOGY	0. 635156	C	6, 50	04 0	0	90.10
	EMERGENCY	0. 145555				0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	1. 083341	C	701, 78	35 0	0	92.00
	R REIMBURSABLE COST CENTERS						
	AMBULANCE SERVICES	0. 407507			0		95.00
200.00	Subtotal (see instructions)		C	34, 555, 28		0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
202.00	Only Charges				07.000	_	202.00
202.00	Net Charges (line 200 - line 201)	I	C	34, 555, 28	87, 992	0	202.00

ANCI LLARY SERVICE COST CENTERS         Cost Reimbursed Subject Tro         Cost Cost Reimbursed Subject Tro         Cost Reimbursed Subject Tro         Part V Syl2/221         Part V Syl2/221           MACI LLARY SERVICE COST CENTERS         Cost Reimbursed         Cost Reimbursed         Cost Reimbursed         Cost Reimbursed         Reimbursed           50:00         05000 OPERATING ROM         512,770         0         0         0           50:00         05000 OPERATING ROM         512,770         0         0         0           50:00         05000 RESPIRATORY THERAPY         95,382         0         0         0           60:00         06000 RESPIRATORY THERAPY         95,382         0		nancial Systems	HARRI SON COUN				u of Form CMS	-2552-10
Cost Center Description         Cost Solution         Cost Center Description         Cost Cost Center Description         Cost Cost Cost Cost Cost Cost Cost Cost	APPORTI ONN	MENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C	CN: 15-1331		Worksheet D Part V Date/Time Pr 5/31/2022 1	repared: 1:29 am
Cost Center Description         Cost Reinbursed Services Subject To Ded: & Coins.         Cost Reinbursed Services Subject To Ded: & Coins.           ANCILLARY SERVICE COST CENTERS         0			_	Title	XVIII	Hospi tal	Cost	
ANCI LLARY SERVICE COST CENTERS         Reinbursed Subject To Ded. & Coins.         Reinbursed Subject To Ded. & Coins.         Reinbursed Subject To Ded. & Coins.           50.00         05000 (PERATI NG ROM         512,770         0           50.00         05000 (ARSTHES) OLOGY         10,737         0           54.00         05400 (ARST NG ROM         512,770         0           65.00         06500 (ARSTHES) OLOGY         10,737         0           66.00         06500 (ARST NG ROMOSTI C         948,829         0           66.00         06500 (LaGORATORY         838,030         0           66.00         06000 (CCUPATI ONAL THERAPY         13,123         0           67.00         0CTOO UCUPATI ONAL THERAPY         138,123         0           67.00         0CTOO UCUPATI ONAL THERAPY         13,8123         0           67.00         0CTOO UCUPATI ONAL THERAPY         13,823         0           71.00         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         293,963         0           72.00         0T200 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         1,160,547         13,237           0017300 DEUGS CHARGED TO PATI ENTS         1,160,547         13,237           0017400 GOT SENIOR CARE         193,701         0           001			Cos	sts				
ANCI LLARY SERVICE COST CENTERS         Services Ded. & Coins. (see inst.)         Services Ded. & Coins. (see inst.)           ANCI LLARY SERVICE COST CENTERS		Cost Center Description						
June 1         Subject To Ded & Coins. (see inst.)         Subject To Ded & Coins. (see inst.)         Ded & Coins. (see inst.)           4NC1 LLARY SERVICE COST CENTERS         6.00         7.00           50.00         05000 (PERATING ROM         512,770         0           54.00         05400 (ANESTHES)         0         0           60.00         06000 (LaBORATORY         948,829         0           66.00         06600 (LABORATORY         133,123         0           67.00         06700 (CCUPATIONAL THERAPY         133,123         0           67.00         06600 SPEECH PATHOLOGY         2,026         0           68.00         06800 SPEECH PATHOLOGY         2,026         0           71.00         07100 MEDICAL SUPPLIES CHARGED TO PATIENTS         293,963         0           71.00         07100 MEDICAL SUPPLIES CHARGED TO PATIENTS         1,160,547         13,237           00.00         07300 DRUGS CHARED TO PATIENTS         1,160,547         13,237           00.01         09000 CLINIC COST CENTERS         17,836         0           00.02         090002 GLINIC COST CENTERS         17,836         0           00.03         09003 JARNISON CRAWEORD HEALTHCARE         13,784         4,595           00.04         09								
Ded % Coins. (see inst.)         Ded % Coins. (see inst.)           ANCILLARY SERVICE COST CENTERS           50.00         05300         PERATING ROOM         512,770         0           53.00         05300         ANESTHESI 0LOGY         10,737         0           60.00         C6000         RESPIRATORY OF AND STIC         948,829         0           60.00         06500         RESPIRATORY THERAPY         95,382         0           61.00         06500         PERSTINATORY THERAPY         133,123         0           67.00         06700         CEURATIONAL THERAPY         10,899         0           68.00         06800         SPECH PATHOLOGY         2,026         0           69.00         06900         SPECH PATHOLOGY         2,026         0           71.00         OTOD MEDI CALSUPPLI ES CHARGED TO PATI ENTS         1,160,547         13,237           OUTPATI ENT SERVICE COST CENTERS         0         0         0           90.00         09000         ILIN C         287,572         0           01         09001         SCHARGED TO PATI ENTS         1,160,547         13,237           001         09001         SCHARGED TO PATI ENTS         1,7836         0								
(see inst.)         (see inst.)         7.00           ANCILLARY SERVICE COST CENTERS         7.00         7.00           50.00         05000         OPERATING ROM         512,770         0           54.00         05000         ANCILLARY SERVICE COST CENTERS         0         0           60.00         06000         ANESTHESIOLOGY         10,737         0           60.00         06000         LABORATORY         838,030         0           66.00         06500         RESPI RATORY THERAPY         95,382         0           67.00         06700         OCCUPATI ONAL THERAPY         10,899         0           68.00         06600         SPECH PATHOLOGY         2,026         0           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         293,963         0           72.00         07200         IMPL. DEV. CHARGED TO PATIENT         287,572         0           70.01         07000         DELCENCARGED TO PATIENT         1,160,547         13,237           00170471ENT SERVICE COST CENTERS         0         0         0         0           00.01         09001 SENI OR CARE         193,701         0         0             00.02         090002								
Image: Not ILLARY SERVICE COST CENTERS           50.00         05000         OPERATING ROOM         512, 770         0           53.00         05300         RADESTHESIOLOGY         10, 737         0           64.00         CAGO RADIOLOGOY-DI AGNOSTIC         948, 829         0           60.00         CAGO RADIOLOGOY-DI AGNOSTIC         948, 829         0           60.00         CAGO RADIOLOGOY-DI AGNOSTIC         948, 829         0           66.00         CAGO OPANDIALORY         838, 030         0           66.00         OFOO OPERATING ROMY         133, 123         0           67.00         OSOO OPHYSICAL THERAPY         133, 123         0           68.00         O6600         SPEECH PATHOLOGY         2, 026         0           71.00         MEDICAL SUPPLIES CHARGED TO PATIENTS         293, 963         0           72.00         O7200 IMPL. DEV. CHARGED TO PATIENTS         1, 160, 547         13, 237           001700 IMPL DEV. CHARGED TO PATIENTS         1, 160, 547         13, 237           001711 ENT SERVICE COST CENTERS         1, 160, 547         13, 237           001700 OLLINIC         17, 836         0           90.01         GPONOI SENIOR CARE         17, 836         0           <								
ANCI LLARY SERVICE COST CENTERS           50.00         05000 OPERATING ROOM         512,770           50.00         05300 ANESTHESI OLOGY         10,737           54.00         05400 RADI OLOCY-DI AGNOSTI C         948,829           60.00         06000 LABORATORY         838,030           65.00         06500 CLESPI RATORY THERAPY         95,382           66.00         0000 CULDATI TONAL THERAPY         133,123           67.00         06700 OCUPATI IONAL THERAPY         10,899           68.00         06600 PHYSI CAL THERAPY         13,899           69.00         06900 ELECTROCARDI OLOGY         2,026           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         293,963           72.00         07200 IMPL.         DEV. CHARGED TO PATI ENTS         1,160,547           73.00         07300 DRUGS CHARGED TO PATI ENTS         1,160,547         13,237           OUTPATI ENT SERVICE COST CENTERS         100000 CLI NIC         0           90.01         09001 SENI OR CARE         193,701         0           90.10         090021 GENERAL SURGERY         57,789         0           90.30         900030 HARRI SON RAWFOR HEALTHCARE         13,784         4,595           90.40         99004 GORYDON MEDI CAL ASSOCI ATES			<i>/</i> /		-			
50.00         05000         OPERATI NG ROOM         512, 770         0           53.00         05300         ANESTHESI LOGY         10, 737         0           64.00         05400         RADI LOGY-DI AGNOSTI C         948, 829         0           65.00         06500         RESPI RATORY THERAPY         933, 803         0           65.00         06500         RESPI RATORY THERAPY         133, 123         0           67.00         06700         OCLUPATI ONAL THERAPY         10, 899         0           68.00         06800 SPECH PATHOLOGY         2, 026         0           69.00         06900 ELECTROCARDI OLOGY         354, 151         0           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         293, 963         0           72.00         07200 IMPL. DEV. CHARGED TO PATI ENT         287, 572         0           73.00         07300 DRUGS CHARGED TO PATI ENT         1, 160, 547         13, 237           0UTPATI ENT SERVICE COST CENTERS         90.00         09000 CLI NI C         17, 836         0           90.10         990001 SELI OR CARE         193, 701         0         0         0           90.20         090003 HARRI SON CRAWFORD HEALTHCARE         13, 784         4, 595         0			6.00	7.00				
53.00       ANESTHESI OLOGY       10,737       0         54.00       OS400       RADI OLOGY-DI AGNOSTI C       948,829       0         60.00       OS000       LABORATORY       838,030       0         65.00       OS600       PHYSI CAL THERAPY       95,382       0         66.00       OG700       OCUPATI ONAL THERAPY       133,123       0         67.00       OG700       OCUPATI ONAL THERAPY       10,899       0         68.00       OB600       ELECTROCARDI OLOGY       2,026       0         69.00       OG900       ELECTROCARDI OLOGY       354,151       0         71.00       OT100       MEDL CAL SUPPLIES CHARGED TO PATI ENT       287,572       0         72.00       OT200       IMPL.       DEV. CHARGED TO PATI ENT       1,160,547       13,237         OUTPATI ENT SERVICE COST CENTERS       17,836       0       0       0000       0000       SENI OR CARE       193,701       0         90.01       O9002       GENERAL SURGERY       57,789       0       0       0000       00000       SENI OR CARE       12,556       3,187       0         90.02       O9005       ORTHOPEDI C SURGERY - DR KLINE       24,334       0       0								
54.00       RADI OLGGY-DI AGNOSTI C       948,829       0         60.00       06000       LABORATORY       838,030       0         65.00       06500       RESPI RATORY THERAPY       95,382       0         66.00       06000       PHYSI CAL THERAPY       133,123       0         67.00       06000       OCCUPATI ONAL THERAPY       10,899       0         68.00       06800       SPEECH PATHOLOGY       2,026       0         69.00       06900       LECTROCARDI OLOGY       2,026       0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       293,963       0         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       287,572       0         017300       DRUGS CHARED TO PATIENTS       1,160,547       13,237         001740       OUTPATIENT SERVICE COST CENTERS       1       1,836       0         90.01       090001       CLINIC       17,836       0       0         90.02       090022       GORZAL SURGERY       137,784       4,595         90.04       09004       CORYDON MEDI CAL ASSOCI ATES       126,004       729         90.05       09005       ORTHOPEDI C SURGERY - DR KLINE       24,334					1			50.00
60.00         LABORATORY         838,030         0           65.00         06500         RESPI RATORY THERAPY         95,382         0           66.00         06600         PHYSI CAL THERAPY         10,899         0           67.00         06700         OCCUPATI ONAL THERAPY         10,899         0           68.00         06800         SPECH PATHOLOGY         2,06         0           71.00         07100         KEDI CAL SUPPLI ES CHARGED TO PATI ENTS         293,963         0           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         1,160,547         13,237           0UTPATI ENT SERVICE COST CENTERS         1,160,547         13,237           0010         O9001         SENIOR CARE         17,836         0           90.01         09001         SENIOR CARE         17,836         0           90.02         09002         GENERAL SURGERY         17,836         0           90.03         09003         HARNI SON CRAWFORD HEALTHCARE         13,789         0           90.04         09004         CORVDON MEDI CAL ASSOCI ATES         126,604         729           90.05         09005         RTHOPEDI C SURGERY - DR KLI NE         24,334         0           9								53.00
65:00       RESPI RATORY THERAPY       95, 382       0         66:00       06600       PHYSI CAL THERAPY       133, 123       0         67:00       06700       00CUPATI ONAL THERAPY       10, 899       0         68:00       06800       SPEECH PATHOLOGY       2, 026       0         69:00       0.6800       SPEECH PATHOLOGY       354, 151       0         71:00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       293, 963       0         72:00       07200       IMPL. DEV. CHARGED TO PATIENT       287, 572       0         0173:00       07000 SCHARGED TO PATIENTS       1, 160, 547       13, 237         0UTPATIENT SERVICE COST CENTERS       11, 160, 547       13, 237         00100       09000       CLINIC       17, 836       0         90:00       09000       CLINIC       17, 836       0         90:01       09000       CARE       193, 701       0         90:02       09002 GENERAL SURGERY       57, 789       0         90:03       09004 CORYDON MEDI CAL ASSOCI ATES       12, 586       3, 187         90:04       09007 FI RST CAPI TAL MEDI CAL GROUP       28, 318       20, 663         90:05       090000       SOUTH					1			54.00
66.00       06600       PHYSI CAL THERAPY       133, 123       0         67.00       0CCUPATI ONAL THERAPY       10, 899       0         68.00       06800       SPEECH PATHOLOGY       2, 026       0         69.00       06900       ELECTROCARDI OLOGY       354, 151       0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       293, 963       0         72.00       7200       IMPL. DEV. CHARGED TO PATI ENTS       1, 160, 547       13, 237         0UTPATI ENT SERVICE COST CENTERS       1, 160, 547       13, 237         0000       09000       CLIN IN C       17, 836       0         90.01       09001       SENI OR CARE       193, 701       0         90.02       09002       GENERAL SURGERY       57, 789       0         90.03       09003       HARRI SON CRAWFORD HEALTHCARE       12, 586       3, 187         90.04       09004       CORYDON MEDI CAL ASSOCI ATES       126, 004       729         90.05       0RTHOPEDI C SURGERY - DR KLINE       24, 334       0         90.06       09000       GOYOO       FLIST CAPI TAL MEDI CAL GROUP       28, 318       20, 663         90.07       090000       FLING FAMILY MEDI CI NE <t< td=""><td></td><td></td><td></td><td></td><td>•</td><td></td><td></td><td>60.00</td></t<>					•			60.00
67.00       06700       0CCUPATI 0NAL THERAPY       10, 899       0         68.00       06800       SPEECH PATHOLOGY       2, 026       0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       293, 963       0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       287, 572       0         001700       DUIGS CHARGED TO PATI ENT       16, 547       13, 237         001701       OUTPATI ENT SERVICE COST CENTERS       17, 836       0         90.00       O9000       CLINIC       17, 836       0         90.01       O9000 2 GENERAL SURGERY       57, 789       0         90.02       09003       HARRI SON CRAWFORD HEALTHCARE       13, 784       4, 595         90.04       09004       CORYDON MEDI CAL ASSOCIATES       126, 004       729         90.05       09005       GTHOPEDI C SURGERY - DR KLINE       24, 334       0         90.06       09007       FI RST CAPI TAL MEDI CAL GROUP       28, 318       20, 663         90.08       SOUTH HARRISON FAMILY MEDI CI NE       44, 334       0         90.09       PAI N MANAGEMENT       493       0         90.09       O9009       PAI N MANAGEMENT       493       0			95, 382					65.00
68.00       06800       SPEECH PATHOLOGY       2,026       0         69.00       06900       ELECTROCARDI OLOGY       354, 151       0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       293, 963       0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       287, 572       0         01700       DEV. CHARGED TO PATI ENTS       1, 160, 547       13, 237         0017971       SENIOR CARE       193, 701       0         90.00       O9000       CLI NI C       17, 836       0         90.01       O9001 SENIOR CARE       193, 701       0         90.02       09002 GENERAL SURGERY       57, 789       0         90.03       09004       CORYDON MEDI CAL ASSOCI ATES       126, 004       729         90.04       09004       CORYDON MEDI CAL ASSOCI ATES       126, 004       729         90.05       09005       ORTHOPEDI C SURGERY - DR KLI NE       28, 318       20, 663         90.06       09006       DBGYN - DR SAUER       12, 586       3, 187         90.07       09007       FIRST CAPI TAL MEDI CAL GROUP       28, 318       20, 663         90.08       09008       SOUTH HARRISON FAMI LY MEDI CI NE       48, 422	66.00 066	00 PHYSI CAL THERAPY	133, 123	0				66.00
69:00       06900       ELECTROCARDIOLOGY       354, 151       0         71:00       MEDI CAL_SUPPLIES CHARGED TO PATIENTS       293, 963       0         72:00       07200       IMPL. DEV. CHARGED TO PATIENT       287, 572       0         70:00       DVUTPATIENT SERVICE COST CENTERS       1, 160, 547       13, 237         00:01       09001       CLINIC       17, 836       0         90:02       09002       GENERAL SURGERY       57, 789       0         90:03       HARRI SON CRAWFORD HEALTHCARE       13, 784       4, 595         90:04       09005       ORYDON MEDI CAL ASSOCIATES       126, 004       729         90:05       09005       ORTHOPEDI C SURGERY - DR KLINE       24, 334       0         90:06       09006       BGNN - DR SAUER       12, 586       3, 187         90:07       09007 FIRST CAPITAL MEDI CAL GROUP       28, 318       20, 663         90:08       900408       SOUTH HARRI SON FAMILY MEDI CINE       44, 323       0         90:09       901       DERMATOLOGY       4, 131       0         90:09       9001       DERMATOLOGY       4, 131       0         91:00       09100       DERMERGENCY       960, 102       5, 363	67.00 067	00 OCCUPATI ONAL THERAPY	10, 899	0				67.00
71.00       O7100       MEDICAL SUPPLIES CHARGED TO PATIENTS       293, 963       0         72.00       IMPL. DEV. CHARGED TO PATIENT       287, 572       0         0000       DRUGS CHARGED TO PATIENTS       1, 160, 547       13, 237         00000       DUTPATIENT SERVICE COST CENTERS       17, 836       0         90.00       09001       SENIOR CARE       193, 701       0         90.01       SENIOR CARE       193, 701       0         90.02       09003       GENERAL SURGERY       57, 789       0         90.03       09004       CORYDON MEDICAL ASSOCIATES       126, 004       729         90.04       09004       CORYDON MEDI CAL ASSOCIATES       126, 004       729         90.05       09005       ORTHOPEDI C SURGERY - DR KLINE       24, 334       0         90.06       09004       OBGYN - DR SAUER       12, 586       3, 187         90.07       09007       FIRST CAPITAL MEDICAL GROUP       28, 318       20, 663         90.08       SOUTH HARRISON FAMILY MEDICINE       48, 422       7, 479         90.09       PAIN       MANAGEMENT       493       0         90.10       OPGNOP       DERMATIONGY       4, 131       0	68.00 068	00 SPEECH PATHOLOGY	2, 026	0				68.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENT       287,572       0         73.00       DRUGS CHARGED TO PATIENTS       1,160,547       13,237         0UTPATIENT SERVICE COST CENTERS       0         90.00       OQ000       CLINIC       17,836       0         90.01       09001       SENIOR CARE       193,701       0         90.02       09002       GENERAL SURGERY       57,789       0         90.03       09003       HARRISON CRAWFORD HEALTHCARE       13,784       4,595         90.04       09004       CORYDON MEDI CAL ASSOCIATES       126,004       729         90.05       09005       OBGYN - DR SAUER       12,586       3,187         90.07       09007       FI RST CAPITAL MEDI CAL GROUP       28,318       20,663         90.08       09008       SOUTH HARI SON FAMILY MEDI CI NE       48,422       7,479         90.10       09009       PAIN MANAGEMENT       493       0         90.10       09010       DERMATOLOGY       4,131       0         91.10       09100       EMERGENCY       960,102       5,363         92.00       OBSERVATION BEDS (NON-DI STINCT PART)       760,272       0         0111       OP200 <td>69.00 069</td> <td>00 ELECTROCARDI OLOGY</td> <td>354, 151</td> <td>0</td> <td>)</td> <td></td> <td></td> <td>69.00</td>	69.00 069	00 ELECTROCARDI OLOGY	354, 151	0	)			69.00
73.00       DRUGS CHARGED TO PATIENTS       1,160,547       13,237         0UTPATIENT SERVICE COST CENTERS       17,836       0         90.01       O90001 CLINIC       17,836       0         90.01       O9001 SENIOR CARE       193,701       0         90.02       O9002 GENERAL SURGERY       57,789       0         90.03       09003 HARRISON CRAWFORD HEALTHCARE       13,784       4,595         90.04       09004 (ORYDON MEDI CAL ASSOCIATES       126,004       729         90.05       09005       ORTHOPEDI C SUBGERY - DR KLINE       24,334       0         90.06       09006 (DBGYN - DR SAUER       12,586       3,187         90.07       09007 FI RST CAPI TAL MEDI CAL GROUP       28,318       20,663         90.08       09008 SOUTH HARRISON FAMILY MEDI CI NE       48,422       7,479         90.10       09009 PAI N MANAGEMENT       493       0         90.10       09101       DERMATOLOGY       4,131       0         91.00       09100       EMERGENCY       960,102       5,363         92.00       09200 (DSERVATION BEDS (NON-DI STINCT PART)       760,272       0         01HER REIMBURSABLE COST CENTERS       0       0       0         00.00	71.00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	293, 963	0				71.00
OUTPATIENT SERVICE COST CENTERS           90.00         09000         CLINIC         17,836         0           90.01         09001         SENIOR CARE         193,701         0           90.02         GENERAL SURGERY         57,789         0           90.03         09003         HARRI SON CRAWFORD HEALTHCARE         13,784         4,595           90.04         0904         CORYDON MEDI CAL ASSOCIATES         126,004         729           90.05         0905         ORTHOPEDI C SURGERY - DR KLINE         24,334         0           90.06         09006         DBGYN - DR SAUER         12,586         3,187           90.07         FIRST CAPITAL MEDI CAL GROUP         28,318         20,663           90.08         SOUTH HARRI SON FAMILY MEDI CI NE         48,422         7,479           90.09         PAIN MANAGEMENT         493         0           90.10         OPCOO         DERMATOLOGY         4,131         0           91.00         DSERVATION BEDS (NON-DI STINCT PART)         760,272         0           91.01         CHTER KEIMBURSABLE COST CENTERS         0         0           91.02         DBERVATION BEDS (NON-DI STINCT PART)         760,272         0           91.04	72.00 072	OO IMPL. DEV. CHARGED TO PATIENT	287, 572	0				72.00
OUTPATI ENT SERVICE COST CENTERS           90.00         09000         CLINIC         17,836         0           90.01         09001         SENIOR CARE         193,701         0           90.02         GENERAL SURGERY         57,789         0           90.03         09003         HARRI SON CRAWFORD HEALTHCARE         13,784         4,595           90.04         0904         CORYDON MEDI CAL ASSOCIATES         126,004         729           90.05         0905         ORTHOPEDI C SURGERY - DR KLINE         24,334         0           90.06         09006         DBGYN - DR SAUER         12,586         3,187           90.07         FIRST CAPI TAL MEDI CAL GROUP         28,318         20,663           90.08         SOUTH HARRI SON FAMILY MEDI CI NE         48,422         7,479           90.09         PAIN MANAGEMENT         493         0           90.10         OPCNO         DERMATOLOGY         4,131         0           91.00         OPCNO         BERGENCY         960,102         5,363           92.00         OBSERVATION BEDS (NON-DI STINCT PART)         760,272         0           0THEV         THBURSABLE COST CENTERS         0         0           00.00 <td< td=""><td>73.00 073</td><td>00 DRUGS CHARGED TO PATIENTS</td><td>1, 160, 547</td><td>13, 237</td><td></td><td></td><td></td><td>73.00</td></td<>	73.00 073	00 DRUGS CHARGED TO PATIENTS	1, 160, 547	13, 237				73.00
90.01       09001       SENIOR CARE       193, 701       0         90.02       09002       GENERAL SURGERY       57, 789       0         90.03       09003       HARRI SON CRAWFORD HEALTHCARE       13, 784       4, 595         90.04       09004       CORYDON MEDI CAL ASSOCIATES       126, 004       729         90.05       09005       ORTHOPEDI C SURGERY - DR KLINE       24, 334       0         90.05       09006       OBGYN - DR SAUER       12, 586       3, 187         90.07       09007       FI RST CAPI TAL MEDI CAL GROUP       28, 318       20, 663         90.08       09008       SOUTH HARRI SON FAMILY MEDI CI NE       493       0         90.10       09010       DERMATOLOGY       4, 131       0         91.00       09100       DERMATOLOGY       960, 102       5, 363         92.00       08SERVATI ON BEDS (NON-DI STI NCT PART)       760, 272       0         91.00       09500       AMBULANCE SERVI CES       0         95.00       09500       AMBULANCE SERVI CES       0         9200.00       Subtotal (see instructions)       6, 895, 801       55, 253         91.00       Less PBP Clinic Lab. Services-Program       0       55, 253	OUTI	PATIENT SERVICE COST CENTERS	·	•				
90.02       09002       GENERAL SURGERY       57,789       0         90.03       09003       HARRI SON CRAWFORD HEALTHCARE       13,784       4,595         90.04       09004       CORYDON MEDI CAL ASSOCI ATES       126,004       729         90.05       09005       ORTHOPEDI C SURGERY - DR KLI NE       24,334       0         90.06       09006       OBGYN - DR SAUER       12,586       3,187         90.07       FI RST CAPI TAL MEDI CAL GROUP       28,318       20,663         90.08       09009       PAI N MANAGEMENT       493       0         90.10       09010       DERMATOLOGY       4,131       0         91.00       09100       EMERGENCY       960,102       5,363         92.00       OBSERVATION BEDS (NON-DI STINCT PART)       760,272       0         07HER       REI MBURSABLE COST CENTERS       0       0         95.00       09500       AMBULANCE SERVICES       0       0         90.00       09500       MBULANCE SERVICES       0       0         90.00       Ubtotal (see instructions)       6,895,801       55,253         91.00       Less PBP Clinic Lab. Services-Program       0       0	90.00 090	OO CLINIC	17, 836	0	)			90.00
90.03       09003       HARRI SON CRAWFORD HEALTHCARE       13,784       4,595         90.04       09004       CORYDON MEDI CAL ASSOCI ATES       126,004       729         90.05       09005       ORTHOPEDI C SURGERY - DR KLINE       24,334       0         90.06       09006       OBGYN - DR SAUER       12,586       3,187         90.07       FI RST CAPI TAL MEDI CAL GROUP       28,318       20,663         90.08       09009       PAI N MANAGEMENT       493       0         90.10       09010       DERMATOLOGY       4,131       0         91.00       09100       EMERGENCY       960,102       5,363         92.00       OSERVATION BEDS (NON-DI STINCT PART)       760,272       0         001HER       REI MBURSABLE COST CENTERS       0       0         92.00       OSERVATION BEDS (NOST CENTERS       0       0         92.00       OSERVATION BEDS (NOST CENTERS       0       0         92.00       OSERVATION SERVICES       0       0         92.00       OSUBOTA       Services-Program       0	90.01 090	01 SENI OR CARE	193, 701	0				90.01
90.04       09004       CORYDON MEDI CAL ASSOCI ATES       126,004       729         90.05       09005       ORTHOPEDI C SURGERY - DR KLINE       24,334       0         90.06       09006       0BGYN - DR SAUER       12,586       3,187         90.07       09007       FI RST CAPI TAL MEDI CAL GROUP       28,318       20,663         90.08       09008       SOUTH HARRI SON FAMILY MEDI CI NE       48,422       7,479         90.09       PAI N MANAGEMENT       493       0         90.10       09010       DERMATOLOGY       4,131       0         91.00       09100       EMERGENCY       960,102       5,363         92.00       092000       DSERVATI ON BEDS (NON-DI STINCT PART)       760,272       0         0THER       REI MBURSABLE COST CENTERS       0       0         95.00       095000       AMBULANCE SERVICES       0         200.00       Subtotal (see instructions)       6,895,801       55,253         201.00       Less PBP Clinic Lab. Services-Program       0       55,253	90. 02 090	02 GENERAL SURGERY	57, 789	0				90.02
90.05       09005       ORTHOPEDIC SURGERY - DR KLINE       24,334       0         90.06       09006       0BGYN - DR SAUER       12,586       3,187         90.07       09007       FIRST CAPITAL MEDICAL GROUP       28,318       20,663         90.08       09008       SOUTH HARRISON FAMILY MEDICINE       48,422       7,479         90.09       09009       PAIN MANAGEMENT       493       0         90.10       09010       DERMATOLOGY       4,131       0         91.00       09200       BSERVATION BEDS (NON-DISTINCT PART)       760,272       0         07HER       REI MBURSABLE COST CENTERS       0       0         95.00       09500       AMBULANCE SERVICES       0         200.00       Subtotal (see instructions)       6,895,801       55,253         201.00       Less PBP Clinic Lab. Services-Program       0	90.03 090	03 HARRISON CRAWFORD HEALTHCARE	13, 784	4, 595				90.03
90.06       09006       0BGYN - DR SAUER       12,586       3,187         90.07       09007       FI RST CAPI TAL MEDI CAL GROUP       28,318       20,663         90.08       09008       SOUTH HARRI SON FAMI LY MEDI CI NE       48,422       7,479         90.09       09009       PAI N MANAGEMENT       493       0         90.10       09010       DERMATOLOGY       4,131       0         91.00       09100       EMREGENCY       960,102       5,363         92.00       0BSERVATI ON BEDS (NON-DI STI NCT PART)       760,272       0         0THER       REI MBURSABLE COST CENTERS       0         95.00       09500       Subtotal (see instructions)       6,895,801       55,253         200.00       Less PBP Clinic Lab. Services-Program       0       55,253	90.04 090	04 CORYDON MEDICAL ASSOCIATES	126,004	729				90.04
90.07       09007       FIRST CAPITAL MEDICAL GROUP       20,318       20,663         90.08       09008       SOUTH HARRISON FAMILY MEDICINE       48,422       7,479         90.09       09009       PAIN MANAGEMENT       493       0         90.10       09010       DERMATOLOGY       4,131       0         91.00       09100       EMERGENCY       960,102       5,363         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       760,272       0         0THER       REI MBURSABLE COST CENTERS       0       0         95.00       09500       AMBULANCE SERVICES       0         200.00       Subtotal (see instructions)       6, 895, 801       55, 253         201.00       Less PBP Clinic Lab. Services-Program       0	90.05 090	05 ORTHOPEDIC SURGERY - DR KLINE	24, 334	0				90.05
90.07         09007         FIRST CAPITAL MEDICAL GROUP         28,318         20,663           90.08         09008         SOUTH HARRISON FAMILY MEDICINE         48,422         7,479           90.09         09009         PAIN MANAGEMENT         493         0           90.10         09010         DERMATOLOGY         4,131         0           91.00         09100         EMERGENCY         960,102         5,363           92.00         085ERVATION BEDS (NON-DISTINCT PART)         760,272         0           0THER         REI MBURSABLE COST CENTERS         0           950.00         09500         AMBULANCE SERVICES         0           920.00         Subtotal (see instructions)         6,895,801         55,253           201.00         Less PBP Clinic Lab. Services-Program         0	90.06 090	06 OBGYN - DR SAUER	12, 586	3, 187				90.00
90.08         09008         SOUTH HARRISON FAMILY MEDICINE         48,422         7,479           90.09         09009         PAIN MANAGEMENT         493         0           90.10         09010         DERMATOLOGY         4,131         0           91.00         09100         EMERGENCY         960,102         5,363           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         760,272         0           0THER         REI MBURSABLE COST CENTERS         0         0           95.00         09500         AMBULANCE SERVICES         0           200.00         Subtotal (see instructions)         6,895,801         55,253           201.00         Less PBP Clinic Lab. Services-Program         0	90. 07 090	07 FIRST CAPITAL MEDICAL GROUP						90.0
90.09         09009         PAIN MANAGEMENT         493         0           90.10         09010         DERMATOLOGY         4,131         0           91.00         09100         EMERGENCY         960,102         5,363           92.00         0BSERVATION BEDS (NON-DISTINCT PART)         760,272         0           0HER         0HERGENCY         0           0HER         REIMBURSABLE COST CENTERS         0           0HER         Subtotal (see instructions)         6,895,801         55,253           201.00         Less PBP Clinic Lab. Services-Program         0         0								90.08
91.00         09100         EMERGENCY         960, 102         5, 363           92.00         09500         0BSERVATION BEDS (NON-DISTINCT PART)         760, 272         0           0THER         REI MBURSABLE COST CENTERS         0         0           95.00         09500         AMBULANCE SERVICES         0           200.00         Subtotal (see instructions)         6, 895, 801         55, 253           201.00         Less PBP Clinic Lab. Services-Program         0								90.09
91.00         09100         EMERGENCY         960, 102         5, 363           92.00         09500         0BSERVATION BEDS (NON-DISTINCT PART)         760, 272         0           0THER         REI MBURSABLE COST CENTERS         0         0           95.00         09500         AMBULANCE SERVICES         0           200.00         Subtotal (see instructions)         6, 895, 801         55, 253           201.00         Less PBP Clinic Lab. Services-Program         0								90.10
92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         760,272         0           0THER         REI MBURSABLE COST CENTERS         0         0           95.00         09500         AMBULANCE SERVICES         0           200.00         Subtotal (see instructions)         6, 895, 801         55, 253           201.00         Less PBP Clinic Lab. Services-Program         0								91.00
OTHER       REI MBURSABLE COST CENTERS         95.00       09500         AMBULANCE SERVICES       0         200.00       Subtotal (see instructions)       6, 895, 801       55, 253         201.00       Less PBP Clinic Lab. Services-Program       0       55, 253								92.00
95.00         09500         AMBULANCE SERVICES         0           200.00         Subtotal (see instructions)         6, 895, 801         55, 253           201.00         Less PBP Clinic Lab. Services-Program         0					1			
200.00         Subtotal (see instructions)         6, 895, 801         55, 253           201.00         Less PBP Clinic Lab. Services-Program         0         0			0					95.00
201.00 Less PBP Clinic Lab. Services-Program 0			-					200.00
								200.00
	231.00	Only Charges						201.00
202. 00 Net Charges (line 200 - line 201) 6, 895, 801 55, 253	202.00		6,895,801	55 253				202.00

Health Finan	ncial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTI ONMEN	NT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-1331	Period: From 01/01/2021	Worksheet D Part V	
					To 12/31/2021	Date/Time Pre	pared:
				e XIX	Hospi tal	5/31/2022 11: Cost	29 am
	·			Charges	nospital	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		9		(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0. 236669				0	50.00
	ANESTHESI OLOGY	0. 027748		1.20/01		0	53.00
	RADI OLOGY-DI AGNOSTI C	0. 099365	C	657, 82		0	54.00
	LABORATORY	0. 149692	C	385, 5		0	60.00
	RESPI RATORY THERAPY	0. 300527		11, 09		0	65.00
	PHYSI CAL THERAPY	0. 241386		6, 4		0	66.00
	OCCUPATIONAL THERAPY	0. 169642		3, 59		0	67.00
	SPEECH PATHOLOGY	0. 078334		3, 10		0	68.00
	ELECTROCARDI OLOGY MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 105684 0. 556357		96, 6		0	69.00 71.00
	IMPL. DEV. CHARGED TO PATIENTS	0. 556357		22, 23	31 0 0 0	0	71.00
	DRUGS CHARGED TO PATIENT	0. 455928				0	72.00
	TIENT SERVICE COST CENTERS	0. 320309		41,0	17 0	0	73.00
		0. 412870	C	75	52 0	0	90.00
	SENI OR CARE	0. 767845		1	0 0	0	90.01
	GENERAL SURGERY	5. 412493	-		13 0	0	90.02
	HARRISON CRAWFORD HEALTHCARE	3. 501988		16, 75		0	90.03
	CORYDON MEDICAL ASSOCIATES	0. 773503		7,38		0	90.04
	ORTHOPEDIC SURGERY - DR KLINE	0. 829341	C C	24, 1		0	90.05
90.06 09006	OBGYN - DR SAUER	2.095240	c c			0	90.06
90.07 09007	FIRST CAPITAL MEDICAL GROUP	3. 886145	C C	9, 10	91 0	0	90.07
90.08 09008	SOUTH HARRISON FAMILY MEDICINE	4. 910441	c c	4, 98	36 0	0	90.08
90.09 09009	PAIN MANAGEMENT	0. 265311	C		0 0	0	90.09
90.10 09010	DERMATOLOGY	0. 635156	C	2,74		0	90.10
	EMERGENCY	0. 145555	C	704, 08	39 0	0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	1. 083341	C		0 0	0	92.00
	REIMBURSABLE COST CENTERS						
	AMBULANCE SERVICES	0. 407507	C				95.00
200.00	Subtotal (see instructions)		C	2, 606, 2		0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
202.00	Only Charges			2 (0) 2	10	_	
202.00	Net Charges (line 200 - line 201)	I	C	2, 606, 2	18 0	0	202.00

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pr 5/31/2022 11	epared: :29 am
		Titl	e XIX	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	20, 972	0				50.00
53. 00 05300 ANESTHESI OLOGY	3, 554	0				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	65, 365	0				54.00
60. 00 06000 LABORATORY	57, 709	0				60.00
65. 00 06500 RESPI RATORY THERAPY	3, 334	0				65.00
66. 00 06600 PHYSI CAL THERAPY	1, 549	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	611	0				67.00
68.00 06800 SPEECH PATHOLOGY	243	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	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 SENI OR CARE	0	0				90.01
90. 02 09002 GENERAL SURGERY	4, 942	0				90.02
90. 03 09003 HARRI SON 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 PALN 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	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	693, 616	0				202.00

	Financial Systems HARRISON COUNTY ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1331	Peri od:	Worksheet D-1	_
			From 01/01/2021 To 12/31/2021		
		Title XVIII	Hospi tal	5/31/2022 11: Cost	29 a
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs excluding newborn)		4, 023	1 1.
00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		3, 939	2
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only p	orivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation k			2, 992	
00	Total swing-bed SNF type inpatient days (including private ror reporting period	oom days) through Decemb	per 31 of the cost	84	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om davs) through Decembe	er 31 of the cost	0	7
	reporting period	5 7 6			
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8
00	Total inpatient days including private room days applicable t	to the Program (excludir	ng swing-bed and	858	9
00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private	room days)	84	10
~~	through December 31 of the cost reporting period (see instruct	ctions)	<b>3 ,</b>		
00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) after	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XI		ate room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	ate room days)	0	13
~~	after December 31 of the cost reporting period (if calendar y	year, enter 0 on this li	ne)		
00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	"am (excluding swing-bed	a days)	0	
	Nursery days (title V or XIX only)			0	
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost		1 17
~~	reporting period	0			
00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost		18
00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 c	of the cost	231.10	19
00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	231. 10	20
00	reporting period Total general inpatient routine service cost (see instruction	)		9, 076, 752	21
00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		
00	5 x line 17) Swing-bed cost applicable to SNF type services after December	- 31 of the cost reporti	ng period (line A	0	23
00	x line 18)	ST OF the cost report	ng period (inne d	0	23
00	Swing-bed cost applicable to NF type services through December $7 \times 1$ (ine 19)	er 31 of the cost report	ing period (line	0	24
00	Swing-bed cost applicable to NF type services after December	31 of the cost reportir	ng period (line 8	0	25
00	x line 20) Total swing-bed cost (see instructions)			189, 522	26
00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		8, 887, 230	
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed o	harges)	0	28
00	Private room charges (excluding swing-bed charges)		sharges)	0	29
00 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0 0. 000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus lino 22)(soo instru	ictions)	0.00 0.00	
00	Average per diem private room cost differential (line 34 x li			0.00	35
00 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing bed cost	and private room cost a	lifferential (line	0 8, 887, 230	
00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)			0, 887, 230	3/
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see			2, 256. 21	38
00	Program general inpatient routine service cost (line 9 x line Medically peoperaty private room cost applicable to the Droom			1, 935, 828	
00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39	•		0 1, 935, 828	

COMPU	Financial Systems ATION OF INPATIENT OPERATING COST	HARRI SON COUNT	Provi der C		Period:	u of Form CMS-2 Worksheet D-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre	
			Title	e XVIII	Hospi tal	5/31/2022 11: Cost	29 am
	Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
40.00		1.00	2.00	3.00	4.00	5.00	10.0
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0 0	0	42.00
43.00 44.00 45.00 46.00 47.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T	1, 223, 940	563	2, 173. 96	216	469, 575	43.00 44.00 45.00 46.00 47.00
47.00	Cost Center Description						47.00
40.00		-+ D 2 2	11			1.00	40.00
48.00 49.00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		1, 161, 460 3, 566, 863	
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
51.00	III) Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D, s	um of Parts II	0	51.00
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-ph	ysician anesth	etist, and	0	53.00
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00 57.00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raet amount (	line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)		inger anount (	The 50 minus	The 33)	0	
59.00							59.0
60. 00 61. 00	0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 1.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by						60.00 61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62.00 63.00		ent (see instru	ctions)			0	
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost reporti	ng period (See	189, 522	64.00
65.00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after Decemb	er 31 of the	cost reporting	period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	l only). For	189, 522	66.00
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost re	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil	2		• •			70.00
71.00 72.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /0 ÷ line	2)			71.00
73.00	Medically necessary private room cost applic	able to Program					73.00
74.00 75.00	Total Program general inpatient routine serv Capital -related cost allocated to inpatient			·	art II, column		74.0 75.0
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ li						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.0
79.00	Aggregate charges to beneficiaries for exces		rovi der recor	ds)			79.0
80.00	Total Program routine service costs for comp		ost limitatio	n (line 78 min	us line 79)		80.0
81.00 82.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81.0
83.00	Reasonable inpatient routine service costs (	see instruction					83.0
84.00	Program inpatient ancillary services (see in		>				84.0
85.00 86.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.00
30.00	PART IV - COMPUTATION OF OBSERVATION BED PAS						
07 00	Total observation bed days (see instructions	·				947	
87.00	Adjusted general inpatient routine cost per		line 2			2, 256. 21	1 00 0

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Pre 5/31/2022 11:	pared: 29 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	728, 647	9, 076, 752	0. 08027	6 2, 136, 631	171, 520	90.00
91.00 Nursing Program cost	0	9, 076, 752	0.00000	0 2, 136, 631	0	91.00
92.00 Allied health cost	0	9, 076, 752	0.00000	0 2, 136, 631	0	92.00
93.00 All other Medical Education	0	9, 076, 752	0.00000	0 2, 136, 631	0	93.00

<sup>5/31/2022 11:29</sup> am

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1331	Period:	Worksheet D-1	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	pare
		Title XIX	Hospi tal	5/31/2022 11: Cost	29
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			4, 023 3, 939	
00 00	Private room days (excluding swing-bed and observation bed da		rivate room davs.	3, 939	
	do not complete this line.				
00	Semi-private room days (excluding swing-bed and observation b		01 -6 +6	2, 992	
00	Total swing-bed SNF type inpatient days (including private reporting period	oom days) through Decemb	er 31 of the cost	84	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
~~	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through Decembe	r 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	/			
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excludin	g swing-bed and	64	9
00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private	room days)	0	10
00	through December 31 of the cost reporting period (see instruc	ctions)			
00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) after	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period				
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar v			0	13
00	Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)		5 .	772	
00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			37	16
00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost		1 17
	reporting period	J. J			
00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost		18
00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 c	f the cost	231. 10	19
00	reporting period	an after December 21 of	the east	221 10	2
00	Medicaid rate for swing-bed NF services applicable to service reporting period	es aiter beceniber 31 01	the cost	231.10	
00	Total general inpatient routine service cost (see instruction			9, 076, 752	21
00	Swing-bed cost applicable to SNF type services through Decemb	ber 31 of the cost repor	ting period (line	0	22
00	5 x line 17) Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line A	0	23
	x line 18)		ng por ou (rino e	Ū.	
00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25
	x line 20)		g por lou (i no o	c c	
00	Total swing-bed cost (see instructions)	(1)		189, 522	
00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		8, 887, 230	27
00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)			0	
00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	÷ 1111e 20)		0.000000	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	, ,	ctions)	0.00	
00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	1110 31)		0. 00 0	
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line		
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			-
	Adjusted general inpatient routine service cost per diem (see			2, 256. 21	38
00	Augusted general inpatrent routine service cost per drem (see			2/200121	
00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	e 38)		144, 397	39

	Financial Systems TION OF INPATIENT OPERATING COST	HARRI SON COUNT	Provider C	CN: 15-1321	In Lie Period:	worksheet D-	
UNPUTA	TION OF INPATIENT OPERATING COST		Provider C	UN. 10-1351	From 01/01/2021		
					To 12/31/2021	Date/Time Pr 5/31/2022 11	
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpati ent	Diem (col. * ÷ col. 2)		(col. 3 x col. 4)	
		1.00	Days 2.00	3.00	4.00	5.00	-
2.00	NURSERY (title V & XIX only)	376, 098	772				5 42.
	ntensive Care Type Inpatient Hospital Units					1	
	INTENSIVE CARE UNIT	1, 223, 940	563	2, 173. 9	96 0	(	) 43.
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.
	SURGICAL INTENSIVE CARE UNIT						45.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description						
	Description in a start and the second second (W		1.1.2.200)	-		1.00	7 40
	Program inpatient ancillary service cost (W Total Program inpatient costs (sum of lines			nns)		71, 127 233, 549	
-	PASS THROUGH COST ADJUSTMENTS	41 through 40)(		51137		233, 34	47.
	Pass through costs applicable to Program in	patient routine	services (fro	m Wkst. D, su	m of Parts I and	) (	50.
	111)						
	Pass through costs applicable to Program in	patient ancillar	ry services (f	rom Wkst. D,	sum of Parts II		51.
	and IV) Total Program excludable cost (sum of lines	50 and 51)				(	52.
	Total Program inpatient operating cost excl		lated, non-ph	ysician anest	hetist, and		53.
	<u>medical education costs (line 49 minus line</u>	52)		-			
	FARGET AMOUNT AND LIMIT COMPUTATION					1	
	Program discharges Target amount per discharge					0.00	) 54 ) 55
	Target amount (line 54 x line 55)						5 56
	Difference between adjusted inpatient opera	ting cost and ta	irget amount (	line 56 minus	line 53)		57
. 00	Bonus payment (see instructions)	-	-				58
	Lesser of lines 53/54 or 55 from the cost r	eporting period	endi ng 1996,	updated and c	ompounded by the	0.00	59
	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	dated by the	market hasket		0.00	0 60
	If line 53/54 is less than the lower of line					0.00	
	which operating costs (line 53) are less th						
	amount (line 56), otherwise enter zero (see	instructions)					
	Relief payment (see instructions)	mant (and instru	ati ana)				) 62. ) 63.
	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST						<u></u>
	Medicare swing-bed SNF inpatient routine co	sts through Dece	mber 31 of th	e cost report	ing period (See	(	64.
	instructions)(title XVIII only)						
	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the	cost reportin	g period (See		) 65.
	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 nlus line	65)(title XVI	ll only) For		66.
	CAH (see instructions)				rr only). For		
	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31	of the cost r	eporting period		) 67.
	(line 12 x line 19)						
	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs arter D	ecember 31 or	the cost rep	orting period		68.
	Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + lin	e 68)			69.
	PART III - SKILLED NURSING FACILITY, OTHER I						
	Skilled nursing facility/other nursing faci				)		70.
	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ine /0 ÷ line	2)			71.
	Medically necessary private room cost appli-		(line 14 x l	ine 35)			73
	Total Program general inpatient routine ser	Ũ					74
. 00	Capital-related cost allocated to inpatient	routine service	costs (from	Norksheet B,	Part II, column		75
	26, line 45) Den diem genitel related geste (line 75 , l	ing 2)					_,
1	Per diem capital-related costs (line 75 ÷ l Program capital-related costs (line 9 x lin						76
	Inpatient routine service cost (line 74 min						78
. 00	Aggregate charges to beneficiaries for exce	ss costs (from p		,			79
	Total Program routine service costs for com	•	ost limitatio	n (line 78 mi	nus line 79)		80
	Inpatient routine service cost per diem lim		)				81
	Inpatient routine service cost limitation ( Reasonable inpatient routine service costs						82
	Program inpatient ancillary services (see i						84
	Utilization review - physician compensation		ons)				85
	Total Program inpatient operating costs (su		rough 85)				86
	PART IV - COMPUTATION OF OBSERVATION BED PAS						7 07
7.00	Total observation bed days (see instruction Adjusted general inpatient routine cost per		lino 2)			947 2, 256. 21	

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Pre 5/31/2022 11:	pared: 29 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	728, 647	9, 076, 752	0. 08027	6 2, 136, 631	171, 520	90.00
91.00 Nursing Program cost	0	9, 076, 752	0.00000	0 2, 136, 631	0	91.00
92.00 Allied health cost	0	9, 076, 752	0.00000	0 2, 136, 631	0	92.00
93.00 All other Medical Education	0	9, 076, 752	0.00000	0 2, 136, 631	0	93.00

<sup>5/31/2022 11:29</sup> am

Health Financial Systems	HARRI SON COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-1331	Peri od:	Worksheet D-3	
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre	pared:
		T: +1 a	XVIII	llooni tol	5/31/2022 11:	29 am
Cast Castan Daganisti an		IIIIE	Ratio of Cos	Hospi tal	Cost	
Cost Center Description					Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
			1.00	2.00	<u>col.2)</u> 3.00	
INDATIENT DOUTINE SEDVICE COST CENTERS			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				1 104 412		20.00
30. 00 03000 ADULTS & PEDIATRICS				1, 184, 412		30.00
31. 00 03100 I NTENSI VE CARE UNI T				579, 056		31.00
43.00 04300 NURSERY						43.00
ANCI LLARY SERVI CE COST CENTERS			0.00//	0 0/5 //4	(0.00)	50.00
50. 00 05000 OPERATING ROOM			0. 2366		62, 826	
53.00 05300 ANESTHESI OLOGY			0.0277			
54.00 05400 RADI OLOGY-DI AGNOSTI C			0. 0993		25, 255	
60. 00 06000 LABORATORY			0. 1496			
65. 00 06500 RESPI RATORY THERAPY			0. 3005			
66. 00 06600 PHYSI CAL THERAPY			0. 2413			
67.00 06700 OCCUPATI ONAL THERAPY			0. 1696			67.00
68.00 06800 SPEECH PATHOLOGY			0. 0783			68.00
69. 00 06900 ELECTROCARDI OLOGY			0. 1056		25, 849	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 5563	57 542, 166	301, 638	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT			0. 4559	28 201, 646	91, 936	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 3265	89 819, 402	267, 608	73.00
OUTPATIENT SERVICE COST CENTERS			_		_	
90. 00 09000 CLI NI C			0. 4128	70 121	50	90.00
90. 01 09001 SENI OR CARE			0. 7678	45 0	0	90.01
90. 02 09002 GENERAL SURGERY			5. 4124	93 0	0	90.02
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE			3. 5019	88 0	0	90.03
90.04 09004 CORYDON MEDICAL ASSOCIATES			0. 7735	0 0	0	90.04
90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE			0. 8293		20	90.05
90. 06 09006 0BGYN - DR SAUER			2.0952	40 0	0	90.06
90. 07 09007 FIRST CAPITAL MEDICAL GROUP			3. 8861	45 0	0	90.07
90. 08 09008 SOUTH HARRISON FAMILY MEDICINE			4. 9104	41 0	0	90.08
90. 09 09009 PALN MANAGEMENT			0. 2653		0	90.09
90. 10 09010 DERMATOLOGY			0. 6351		0	90.10
91. 00 09100 EMERGENCY			0. 1455			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			1.0833			92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (sum of lines 50 through 94 and 9	6 through 98)			4, 181, 773	1, 161, 460	
201.00 Less PBP Clinic Laboratory Services-Pro		(line 61)		4, 101, 7, 73		201.00
202.00 Net charges (line 200 minus line 201)	gram only charges			4, 181, 773		201.00
			I	T, 101, 773	I	1202.00

	COUNTY HOSPI TAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1331	Peri od:	Worksheet D-3	
	Component	CCN: 15-Z331	From 01/01/2021 To 12/31/2021	Date/Time Pre	pared
	oomponone			5/31/2022 11:	29 am
	Title		Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	<u>col.2)</u> 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS					30. C
31. 00 03100 I NTENSI VE CARE UNI T					31.0
43. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS					1 .0.0
50. 00 05000 OPERATI NG ROOM		0. 2366	59 0	0	1 50. c
53. 00 05300 ANESTHESI OLOGY		0. 0277	48 0	0	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0993	5 2, 262	225	54.0
60. 00 06000 LABORATORY		0. 1496	92 11, 632	1, 741	60. C
65. 00 06500 RESPI RATORY THERAPY		0. 3005	27 19, 445	5, 844	65.C
66. 00 06600 PHYSI CAL THERAPY		0. 2413	36 36, 960	8, 922	66. C
67. 00 06700 OCCUPATI ONAL THERAPY		0. 1696	42 28, 651	4, 860	67.0
68.00 06800 SPEECH PATHOLOGY		0. 0783	34 0	0	68.0
69. 00 06900 ELECTROCARDI OLOGY		0. 1056	34 422	45	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5563		11, 402	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 45592		0	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3265	39 14, 809	4, 836	73. C
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 4128			
90. 01 09001 SENI OR CARE		0. 7678			90.0
90. 02 09002 GENERAL SURGERY		5. 4124			90.0
90. 03 09003 HARRI SON CRAWFORD HEALTHCARE		3. 50198 0. 77350			90.0
90. 04 09004 CORYDON MEDICAL ASSOCIATES 90. 05 09005 ORTHOPEDIC SURGERY - DR KLINE		0. 77350			90.0
90.06 09006 OBGYN - DR SAUER		2. 0952			90.0
90. 07 09000 DGTN - DR SAUER 90. 07 09007 FIRST CAPITAL MEDICAL GROUP		3. 8861			90.0
90. 08 09008 SOUTH HARRI SON FAMILY MEDICINE		4. 9104			90.0
90. 09 09008 SOUTH HARRISON FAMILY MEDICINE 90. 09 09009 PAIN MANAGEMENT		0. 2653			90.0
90. 10  09010  PATN MANAGEMENT 90. 10  09010  DERMATOLOGY		0. 2053		0	90.0
91. 00 09100 EMERGENCY		0. 1455			91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 0833		0	92.0
OTHER REIMBURSABLE COST CENTERS		1.0000			1 /2.0
95. 00 09500 AMBULANCE SERVICES					95.0
200.00 Total (sum of lines 50 through 94 and 96 through	98)		134, 675	37, 875	
201.00 Less PBP Clinic Laboratory Services-Program only			0		201.0
202.00 Net charges (line 200 minus line 201)	5		134, 675		202.0

Health Financial		HARRISON COUNTY HOSPIT			In Lie	u of Form CMS-2	2552-1
INPATIENT ANCILL	ARY SERVICE COST APPORTIONMENT	Provid	der CC	N: 15-1331	Period:	Worksheet D-3	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	narod
					10 12/31/2021	5/31/2022 11:	29 am
			Title	e XIX	Hospi tal	Cost	27 am
Cost	Center Description			Ratio of Cos		I npati ent	
				To Charges	Program	Program Costs	
				5	Charges	(col. 1 x	
					J	col. 2)	
				1.00	2.00	3.00	
	ROUTINE SERVICE COST CENTERS						
	TS & PEDIATRICS				332, 486		30.0
	NSIVE CARE UNIT				0		31.0
43.00 04300 NURS					115, 279		43.0
	SERVICE COST CENTERS						
50.00 05000 OPER				0. 2366			50.0
53.00 05300 ANES	THESI OLOGY			0. 0277	48 13, 900	386	53.0
54.00 05400 RADI	OLOGY-DI AGNOSTI C			0.0993	65 17, 187	1, 708	54.0
60.00 06000 LAB0	RATORY			0. 1496	92 99, 719	14, 927	60.0
65.00 06500 RESP	I RATORY THERAPY			0. 3005	27 67, 615	20, 320	65.0
66.00 06600 PHYS	I CAL THERAPY			0. 2413	B6 6, 975	1, 684	66.0
67.00 06700 0CCU	PATIONAL THERAPY			0. 1696	42 4, 385	744	67.0
68.00 06800 SPEE	CH PATHOLOGY			0. 0783	34 0	0	68.0
69.00 06900 ELEC	TROCARDI OLOGY			0. 1056	6, 712	709	69.0
71.00 07100 MEDI	CAL SUPPLIES CHARGED TO PATIENTS	5		0. 5563	57 10, 589	5, 891	71.0
72.00 07200 I MPL	. DEV. CHARGED TO PATIENT			0.45592	28 0	0	72.0
73.00 07300 DRUG	S CHARGED TO PATIENTS			0. 3265	89 48, 152	15, 726	73.0
OUTPATI ENT	SERVICE COST CENTERS						1
90.00 09000 CLIN	IC			0. 4128	70 0	0	90.0
90.01 09001 SENI	OR CARE			0. 7678	45 0	0	90.0
90.02 09002 GENE	RAL SURGERY			5. 4124	93 0	0	90.0
90.03 09003 HARR	ISON CRAWFORD HEALTHCARE			3. 5019	88 0	0	90.0
90.04 09004 CORY	DON MEDICAL ASSOCIATES			0.77350	0 0	0	90.0
90. 05 09005 ORTH	OPEDIC SURGERY - DR KLINE			0. 8293	41 0	0	90.0
90.06 09006 0BGY	N – DR SAUER			2.0952	40 0	0	90.0
90.07 09007 FIRS	T CAPITAL MEDICAL GROUP			3. 8861	45 0	0	90.0
90. 08 09008 SOUT	H HARRISON FAMILY MEDICINE			4.9104	41 0	0	90.0
	MANAGEMENT			0. 2653		0	90.0
90. 10 09010 DERM				0. 6351		0	90.1
91.00 09100 EMER				0. 1455		898	
	RVATION BEDS (NON-DISTINCT PART)			1.0833		0	92.0
	BURSABLE COST CENTERS						1
	LANCE SERVICES						95.0
	l (sum of lines 50 through 94 ar	nd 96 through 98)			315, 773	71, 127	
	PBP Clinic Laboratory Services-		61)		010,770	,,	201.0
	charges (line 200 minus line 201		,		315, 773		202.0

INPATI ENT ROUTI NE SERVI CE COST CENTERS           0.00         03000         ADULTS & PEDI ATRI CS           31.00         03100         INTENSI VE CARE UNI T           43.00         04300         NURSERY           ANGL LARY SERVI CE COST CENTERS		In Lie	u of Form CMS-2	2552-1
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         03000 ADULTS & PEDI ATRI CS           31.00         03100 INTENSI VE CARE UNI T           43.00         04300 NURSERY           ANCI LLARY SERVI CE COST CENTERS           50.00         05300 OPERATI NG ROOM           53.00         05300 OPERATI NG ROOM           53.00         05300 ANESTHESI OLOGY           54.00         05400 RADI OLOGY - DI AGNOSTI C           60.00         06500 LABORATORY           65.00         06500 RESPI RATORY THERAPY           66.00         06600 PHYSI CAL THERAPY           66.00         06600 SPEECH PATHOLOGY           69.00         06600 SECH PATHOLOGY           69.00         06600 SPECCH PATHOLOGY           69.00         06900 ELECTROCARDI OLOGY           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS           72.00         07200 IMPL. DEV. CHARGED TO PATI ENTS           73.00         07200 IMPL. DEV. CHARGED TO PATI ENTS           70.00         07000 SENI GR CARE           90.00         09000 CLI NI C           90.01         09000 SURA SURGERY           90.02         09002 GENERAL SURGERY           90.03         09003 HARRI SON CRAWFORD HEALTHCARE           90.04		Peri od:	Worksheet D-3	8
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         03000 ADULTS & PEDI ATRI CS           31.00         03100 INTENSI VE CARE UNI T           43.00         04300 NURSERY           ANCI LLARY SERVI CE COST CENTERS           50.00         05300 OPERATI NG ROOM           53.00         05300 OPERATI NG ROOM           53.00         05300 ANESTHESI OLOGY           54.00         05400 RADI OLOGY - DI AGNOSTI C           60.00         06500 LABORATORY           65.00         06500 RESPI RATORY THERAPY           66.00         06600 PHYSI CAL THERAPY           66.00         06600 SPEECH PATHOLOGY           69.00         06600 SECH PATHOLOGY           69.00         06600 SPECCH PATHOLOGY           69.00         06900 ELECTROCARDI OLOGY           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS           72.00         07200 IMPL. DEV. CHARGED TO PATI ENTS           73.00         07200 IMPL. DEV. CHARGED TO PATI ENTS           70.00         07000 SENI GR CARE           90.00         09000 CLI NI C           90.01         09000 SURA SURGERY           90.02         09002 GENERAL SURGERY           90.03         09003 HARRI SON CRAWFORD HEALTHCARE           90.04		From 01/01/2021 To 12/31/2021	Date/Time Pre	nared
Cost Center Description         Ra           30.00         O3000 ADULTS & PEDIATRICS         03000           31.00         03100   INTENSI VE CARE UNI T         04300           43.00         04300 NURSERY         04300           ANCILLARY SERVICE COST CENTERS         05400           54.00         05400 PERATI NG ROOM           54.00         05400 RADI OLOGY           54.00         06600 LABORATORY           65.00         06500 RESPI RATORY THERAPY           66.00         06600 PHYSI CAL THERAPY           67.00         06700 OCCUPATI ONAL THERAPY           68.00         06600 SPEECH PATHOLOGY           69.00         06900 ELECTROCARDI OLOGY           71.00         07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           72.00         07200 IMPL. DEV. CHARGED TO PATI ENT           73.00         07300 DRUGS CHARGED TO PATI ENTS           00.11         09001 SEN IOR CARE           90.02         09002 GENERAL SURGERY           90.03         09003 HARI SON CRAWFORD HEALTHCARE           90.04         09004 CORVDON MEDI CAL ASSOCI ATES           90.07         09007 FLIST CAPI TAL MEDI CAL GROUP           90.08         09004 HARI SON FAMILY MEDI CINE           90.07         09007 FLIST CAPI TAL MEDI CAL GROU	N. 15 2551	10 12/31/2021	5/31/2022 11:	29 am
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         03000 ADULTS & PEDI ATRI CS           31.00         03100 INTENSI VE CARE UNI T           43.00         UNSERY           ANCILLARY SERVI CE COST CENTERS           50.00         05000 OPERATI NG ROOM           53.00         05300 ANESTHESI OLOGY           54.00         54.00           50.00         06500 RESPI RATORY           65.00         06500 RESPI RATORY THERAPY           66.00         6600 PHYSI CAL THERAPY           67.00         06700 OCCUPATI ONAL THERAPY           68.00         06600 ELECTROCARDI OLOGY           71.00         07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           72.00         07200 I IMPL. DEV. CHARGED TO PATI ENTS           001700 OUTPATI ENT SERVI CE COST CENTERS         0010 09000 CLETROCARDI OLOGY           011 09001 SEN IOR CARE         0010 09001 SEN IOR CARE           00.01         09001 SEN IOR CARE           00.02         09002 GENERAL SURGERY           00.03         09003 MARTISON CRAWFORD HEALTHCARE           00.04         09004 CORYDON MEDI CAL ASSOCI ATES           00.05         09005 ORTHOPEDI C SURGERY - D R KLINE           00.06         090004 GORYDON MEDI CAL ASSOCI ATES           00.07         0900		Swing Beds - SNF	Cost	
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         03000 ADULTS & PEDI ATRI CS           31.00         03100 INTENI VE CARE UNI T           43.00         04300 NURSERY           ANCI LLARY SERVI CE COST CENTERS           50.00         05000 OPERATI NG ROM           51.00         05300 ANESTHESI OLOGY           54.00         05400 RADI OLOGY-DI AGNOSTI C           60.00         06500 RESPI RATORY THERAPY           65.00         06500 OCCUPATI ONAL THERAPY           66.00         06600 SPEECH PATHOLOGY           67.00         06700 OCCUPATI ONAL THERAPY           68.00         06600 SPEECH PATHOLOGY           69.00         06900 ELECTROCARDI OLOGY           71.00         07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           72.00         07200 IMPL. DEV. CHARGED TO PATI ENTS           73.00         07300 DRUGS CHARGED TO PATI ENTS           001         09001 CLI NI C           002         09002 GENERAL SURGERY           90.01         09002 GENERAL SURGERY           90.02         09003 HARRI SON CRAWFOR HEALTHCARE           90.03         09003 HARRI SON CRAWFORD HEALTHCARE           90.04         09004 CORYDON MEDI CAL ASSOCI ATES           90.05         09005 ORTHOPEDI C SURGERY - DR KLINE <td>Ratio of Cos</td> <td>t Inpatient</td> <td>I npati ent</td> <td></td>	Ratio of Cos	t Inpatient	I npati ent	
30.00       03000       ADULTS & PEDIATRICS         31.00       1XTENSIVE CARE UNIT         43.00       04300       NURSERY         ANCILLARY SERVICE COST CENTERS         50.00       05000       OPERATING ROOM         53.00       05300       ANESTHESIOLOGY         54.00       05400       RADIOLOGY-DI AGNOSTIC         60.00       06600       LABORATORY         65.00       06500       RESPIRATORY THERAPY         66.00       06600       PHYSICAL THERAPY         67.00       06700       CCUPATIONAL THERAPY         67.00       06700       CEUROCARDIOLOGY         69.00       06900       ELECTROCARDIOLOGY         69.00       06900       ELECTROCARDIOLOGY         69.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS         001       09000       CLINIC         90.00       09000       CLINIC         90.01       09001       SENIOR CARE         90.02       09002       GENERAL SURGERY         90.03       09003       HARISON CRAWFORD HEALTHCARE         90.04       09004       CORTPON MEDI CAL ASSOCI ATES	To Charges	Program	Program Costs	
30.00       03000       ADULTS & PEDIATRICS         31.00       INTENSIVE CARE UNIT         43.00       04300       NURSERY         ANCILLARY SERVICE COST CENTERS         50.00       05000       OPERATING ROOM         53.00       05300       ANESTHESIOLOGY         54.00       05400       RADIOLOGY-DI AGNOSTIC         60.00       06000       LABORATORY         65.00       06500       RESPI RATORY THERAPY         66.00       06600       PHYSICAL THERAPY         67.00       06700       CCUPATIONAL THERAPY         68.00       06600       SPEECH PATHOLOGY         69.00       06900       ELECTROCARDIOLOGY         69.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS         00       07300       DRUGS CHARGED TO PATIENTS         00.10       09001       SENIOR CARE         90.01       09002       CLINIC         90.02       09002       GENERAL SURGERY         90.03       09003       HARRISON CRAWFORD HEALTHCARE         90.04       09004       CORTDON MEDI CAL ASSOCI ATES         90.05       097HOPEDIC SURGERY - DR KLINE		Charges	(col. 1 x	
30.00       03000       ADULTS & PEDIATRICS         31.00       1XTENSIVE CARE UNIT         43.00       04300       NURSERY         ANCILLARY SERVICE COST CENTERS         50.00       05000       OPERATING ROOM         53.00       05300       ANESTHESIOLOGY         54.00       05400       RADIOLOGY-DI AGNOSTIC         60.00       06600       LABORATORY         65.00       06500       RESPIRATORY THERAPY         66.00       06600       PHYSICAL THERAPY         67.00       06700       CCUPATIONAL THERAPY         67.00       06700       CEUROCARDIOLOGY         69.00       06900       ELECTROCARDIOLOGY         69.00       06900       ELECTROCARDIOLOGY         69.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS         001       09000       CLINIC         90.00       09000       CLINIC         90.01       09001       SENIOR CARE         90.02       09002       GENERAL SURGERY         90.03       09003       HARISON CRAWFORD HEALTHCARE         90.04       09004       CORTPON MEDI CAL ASSOCI ATES			col. 2)	
30.00       03000       ADULTS & PEDIATRICS         31.00       INTENSIVE CARE UNIT         43.00       04300       NURSERY         ANCILLARY SERVICE COST CENTERS         50.00       05000       OPERATING ROOM         53.00       05300       ANESTHESIOLOGY         54.00       05400       RADIOLOGY-DI AGNOSTIC         60.00       06000       LABORATORY         65.00       06500       RESPI RATORY THERAPY         66.00       06600       PHYSICAL THERAPY         67.00       06700       CCUPATIONAL THERAPY         68.00       06600       SPEECH PATHOLOGY         69.00       06900       ELECTROCARDIOLOGY         69.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS         00       07300       DRUGS CHARGED TO PATIENTS         00.10       09001       SENIOR CARE         90.01       09002       CLINIC         90.02       09002       GENERAL SURGERY         90.03       09003       HARRISON CRAWFORD HEALTHCARE         90.04       09004       CORTDON MEDI CAL ASSOCI ATES         90.05       097HOPEDIC SURGERY - DR KLINE	1.00	2.00	3.00	
31.00       03100       INTENSIVE CARE UNIT         43.00       NURSERY         ANCILLARY SERVICE COST CENTERS         50.00       OS000         05300       ANESTHESI OLOGY         54.00       O5400         06500       RADI OLOGY-DI AGNOSTI C         60.00       O6500         06500       RESPI RATORY         66.00       O6600         06600       PHYSI CAL THERAPY         66.00       O6600         06800       SPECH PATHOLOGY         67.00       OCOUPATI ONAL THERAPY         68.00       O6600         68.00       O6600         06400       RESPI RATORY THERAPY         68.00       O6600         00       OCUPATI ONAL THERAPY         68.00       O6600         00       OCUPATI ONAL THERAPY         68.00       ORGON         00       OTOO DRUGS CHARGED TO PATI ENTS         010       OTOO IMPL. DEV. CHARGED TO PATI ENTS         0110       MUTPATI ENT SERVICE COST CENTERS         00.01       OPOOL CLINIC         00.02       OPOOL CLINIC         00.03       OPOOL CLINIC         00.04       OPOOL CLINIC <t< td=""><td></td><td></td><td></td><td></td></t<>				
43. 00         04300         NURSERY           ANCILLARY SERVICE COST CENTERS           50. 00         OPERATING ROM           51. 00         05300         ANESTHESI OLOGY           54. 00         05400         RADI OLOGY-DI AGNOSTI C           60. 00         06000         LABORATORY           65. 00         06500         RESPI RATORY THERAPY           66. 00         06600         PHYSI CAL THERAPY           67. 00         06700         OCCUPATI ONAL THERAPY           68. 00         06800         SPEECH PATHOLOGY           71. 00         OT200         IMPL. DEV. CHARGED TO PATI ENTS           72. 00         07200         IMPL. DEV. CHARGED TO PATI ENTS           73. 00         07300         DRUGS CHARGED TO PATI ENTS           00. 01         09000         CLI NI C           00. 02         09002         GENERAL SURGERY           90. 01         09001         SENI OR CARE           90. 02         09002         GENERAL SURGERY           90. 04         09004         CORYDON MEDI CAL ASSOCI ATES           90. 05         ORTHOPEDI C SURGERY - DR KLI NE           90. 06         09006         GBGN - DR SAUER           90. 07         FIR ST CAPI TAL MEDI CAL GRO				30.0
ANCI LLARY SERVICE COST CENTERS           50.00         05000         OPERATI NG ROOM           53.00         05300         ANESTHESI OLOGY           54.00         05400         RADI OLOGY-DI AGNOSTI C           60.00         06600         LABORATORY           65.00         06500         RESPI RATORY THERAPY           66.00         06600         PHYSI CAL THERAPY           67.00         0CCUPATI ONAL THERAPY           68.00         06600         SPEECH PATHOLOGY           69.00         06600         SPEECH PATHOLOGY           69.00         06700         CCURATI ONAL THERAPY           68.00         06600         SPEECH PATHOLOGY           69.00         06700         ELECTROCARDI OLOGY           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           72.00         D7200         IMPL. DEV. CHARGED TO PATI ENTS           0017201         IMPL. DEV. CHARGED TO PATI ENTS           0017202         GOUD2         GENERAL SURGERY           90.01         09001         CLI NI C           90.02         GOUD2         GENERAL SURGERY           90.03         09003         HARRI SON CRAWFORD HEALTHCARE           90.04         09004 <td< td=""><td></td><td></td><td></td><td>31.0</td></td<>				31.0
50.00       05000       OPERATING ROOM         53.00       05300       ANESTHESI 0 LOGY         54.00       05400       RADI 0 LOGY-DI AGNOSTI C         60.00       06000       LABORATORY         65.00       06500       RESPI RATORY THERAPY         66.00       06600       PHYSI CAL THERAPY         67.00       06700       0CUPATI ONAL THERAPY         68.00       06800       SPEECH PATHOLOGY         69.00       06900       ELECTROCARDI 0LOGY         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         72.00       07200 I MPL.       DEV. CHARGED TO PATI ENT         73.00       DRUGS CHARGED TO PATI ENTS         0UTPATI ENT SERVI CE COST CENTERS         90.00       09000 CLI NI C         90.01       09001 SENI OR CARE         90.02       09002 GENERAL SURGERY         90.03       09003 HARRI SON CRAWFORD HEALTHCARE         90.04       09004 CORVDON MEDI CAL ASSOCI ATES         90.05       09005 ORTHOPEDI C SURGERY - DR KLI NE         90.06       09006 JBGYN - DR SAUER         90.07       FIR ST CAPI TAL MEDI CAL GROUP         90.08       SOUTH HARRI SON FAMI LY MEDI CI NE         90.09       PAI N MANAGEMENT				43.0
53.00       05300       ANESTHESI OLOGY         54.00       05400       RADI OLOGY-DI AGNOSTI C         60.00       06000       LABORATORY         65.00       06500       RESPI RATORY THERAPY         66.00       06600       PHYSI CAL THERAPY         67.00       06700       OCCUPATI ONAL THERAPY         67.00       06700       DCUPATI ONAL THERAPY         68.00       06800       SPEECH PATHOLOGY         69.00       06900       ELECTROCARDI OLOGY         71.00       OT100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS         73.00       07300       DRUGS CHARGED TO PATI ENTS         90.01       09001       SENI OR CARE         90.02       09002       GENERAL SURGERY         90.03       09003       HARRI SON CRAWFORD HEALTHCARE         90.04       09004       CORYDON MEDI CAL ASSOCI ATES         90.05       09005       ORTHOPEDI C SURGERY - DR KLI NE         90.06       09005       ORTHOPEDI C SURGERY - DR KLI NE         90.07       09007       FI RST CAPI TAL MEDI CAL GROUP         90.08       SOUTH HARRI SON FAMI LY MEDI CI NE         90.09	0. 23666	59 0	0	50.0
54.00       05400       RADI OLOGY-DI AGNOSTI C         60.00       06000       LABORATORY         65.00       06500       RESPI RATORY THERAPY         66.00       06400       PHYSI CAL THERAPY         66.00       06700       OCCUPATI ONAL THERAPY         68.00       06800       SPEECH PATHOLOGY         69.00       06900       ELECTROCARDI OLOGY         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENT         73.00       07300       DRUGS CHARGED TO PATI ENTS         0UTPATI ENT SERVI CE COST CENTERS       0017001       SENI OR CARE         90.00       09000       CLI NI C       9001         90.10       09001       SENI OR CARE       9003         90.02       GENERAL SURGERY       90       9003         90.03       09004       CORYDON MEDI CAL ASSOCI ATES       90         90.04       09004       CORYDON MEDI CAL GROUP       90         90.05       09005       ORTHOPEDI C SURGERY - DR KLI NE       90         90.06       09006       BGYN - DR SAUER       90         90.07       FIR ST CAPI TAL MEDI CAL GROUP       90       90	0. 23000			
60.00         06000         LABORATORY           65.00         06500         RESPI RATORY THERAPY           66.00         06600         PHYSI CAL THERAPY           67.00         06700         OCCUPATI ONAL THERAPY           68.00         06800         SPEECH PATHOLOGY           68.00         06900         ELECTROCARDI OLOGY           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           72.00         07200         IMPL.         DEV. CHARGED TO PATI ENTS           00         07300         DRUGS CHARGED TO PATI ENTS           00         07000         CLIN C           00.00         09000         CLIN C           90.00         09000         CLIN C           90.01         09000         CLIN C           90.02         GENERAL SURGERY           90.03         09003         HARRI SON CRAWFORD HEALTHCARE           90.04         09004         CORYDON MEDI CAL ASSOCI ATES           90.05         ORTHOPEDI C SURGERY - DR KLI NE           90.06         09005         ORTHOPEDI C SURGERY - DR KLI NE           90.07         09007         FI RST CAPI TAL MEDI CAL GROUP           90.08         SOUTH HARRI SON FAMI LY MEDI CI NE           9	0. 02774			
655.00         06500         RESPI RATORY THERAPY           66.00         06600         PHYSI CAL THERAPY           67.00         06700         OCCUPATI ONAL THERAPY           68.00         0800         SPEECH PATHOLOGY           69.00         06900         ELECTROCARDI OLOGY           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           72.00         07200         IMPL.         DEV. CHARGED TO PATI ENTS           73.00         07300         DRUGS CHARGED TO PATI ENTS           0017041         ENT SERVI CE COST CENTERS           0017041         SENI OR CARE           90.01         09000         CLINI C           90.02         GENERAL SURGERY           90.03         09003         HARRI SON CRAWFORD HEALTHCARE           90.04         09004         CORYDON MEDI CAL ASSOCI ATES           90.05         ORTHOPEDI C SURGERY - DR KLI NE           90.06         09005         ORTHOPEDI C SURGERY - DR KLI NE           90.07         09007         FI RST CAPI TAL MEDI CAL GROUP           90.08         SOUTH HARRI SON FAMI LY MEDI CI NE           90.09         9009         PAI N MANAGEMENT           90.10         09010         DERMATOLOGY           9	0. 14969			
66.00       06600       PHYSI CAL THERAPY         67.00       06700       OCCUPATI ONAL THERAPY         68.00       06800       SPEECH PATHOLOGY         69.00       06900       ELECTROCARDI OLOGY         71.00       OT100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT         73.00       07300       DRUGS CHARGED TO PATI ENTS         0UTPATI ENT SERVI CE COST CENTERS       0UTPATI ENT SERVI CE COST CENTERS         90.00       09000       CLI NI C         90.01       09001       SENI OR CARE         90.02       09002       GENERAL SURGERY         90.03       HARRI SON CRAWFORD HEALTHCARE         90.04       09004       CORYDON MEDI CAL ASSOCI ATES         90.05       09005       ORTHOPEDI C. SURGERY - DR KLI NE         90.06       09006       OBGYN - DR SAUER         90.07       09007       FI RST CAPI TAL MEDI CAL GROUP         90.08       09008       SOUTH HARI SON FAMI LY MEDI CI NE         90.09       09009       PAI N MANAGEMENT         90.10       09010       DERMATOLOGY         91.00       09100       EMERGENCY         92.00       092000       DBSERVA	0. 30052			65.0
57.00       06700       OCCUPATI ONAL THERAPY         58.00       06800       SPEECH PATHOLOGY         59.00       06900       ELECTROCARDI OLOGY         59.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS         07300       DRUGS CHARGED TO PATI ENTS       00000         0017PATI ENT SERVI CE COST CENTERS       00000         0000       CLI NI C         00.00       09000       CLI NI C         00.01       09001       SENI OR CARE         00.02       09002       GENERAL SURGERY         00.03       09003       HARRI SON CRAWFORD HEALTHCARE         00.04       09004       CORJDON MEDI CAL ASSOCI ATES         00.05       097HOPEDI C SURGERY - DR KLI NE         00.06       09005       ORTHOPEDI C SURGERY - DR KLI NE         00.07       09007       FI RST CAPI TAL MEDI CAL GROUP         00.08       09008       SOUTH HARRI SON FAMI LY MEDI CI NE         00.09       09009       PAI N MANAGEMENT         00.09       09009       PAI N MANAGEMENT         00.00       09000       EMERGENCY         00.00       09000       BERVATI ON BEDS (NON-DI STI NC	0. 24138			
58.00         06800         SPEECH PATHOLOGY           59.00         06900         ELECTROCARDI OLOGY           59.00         06900         ELECTROCARDI OLOGY           71.00         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           72.00         07200         IMPL.           07300         DRUGS CHARGED TO PATI ENT           0000         CLI NI C           00100         COST CENTERS           00.01         SENI OR CARE           00.02         GP000           0000         CLI NI C           00.02         GP000           0000         CLI NI C           00.02         GP000           0000         CLI NI C           00.03         09003           0000         CLI NI C           00.02         GP000           0000         CLI NI C           00.03         09003           00004         CORWERN           00.05         ORTHOPEDI C SURGERY - DR KLI NE           00.06         09004           00007         FI RST CAPI TAL MEDI CAL GROUP           00.08         09008           00009         PAI N MANAGEMENT           00.010         DEMATOLOGY	0. 24130			67.0
59.00         06900         ELECTROCARDI OLOGY           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           72.00         07200         IMPL. DEV. CHARGED TO PATI ENT           00         07300         DRUGS CHARGED TO PATI ENTS           0UTPATI ENT SERVI CE COST CENTERS           0000         CLI NI C           20.01         09001           20.02         GENERAL SURGERY           20.03         09003           20.04         COYDON MEDI CAL ASSOCI ATES           20.05         09004           20.06         OBGEN - DR SAUER           20.07         09005           20.08         OBGYN - DR SAUER           20.09         OPO06           20.09         PATI ENT CAPI TAL MEDI CAL GROUP           20.09         OPO09           20.09         OPO09           20.09         OPO09           20.09         OPO09           20.00         OPO009           20.01         OPO01           20.02         OPO02           20.03         OPO04           20.04         OPO04           20.05         OPO05           20.06         OPO06           <	0. 07833		-	
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         72.00       07200       I MPL.       DEV. CHARGED TO PATI ENT         73.00       DRUGS CHARGED TO PATI ENTS       DUTPATI ENT SERVI CE COST CENTERS         00.00       O9000       CLI NI C         70.01       90001       SENI OR CARE         70.02       09002       GENERAL SURGERY         70.03       09003       HARRI SON CRAWFORD HEALTHCARE         70.04       09004       CORYDON MEDI CAL ASSOCI ATES         70.05       09005       ORTHOPEDI C SURGERY - DR KLI NE         70.06       09004       CORYDON MEDI CAL ASSOCI ATES         70.07       09005       ORTHOPEDI C SURGERY - DR KLI NE         70.08       09005       ORTHOPEDI C SURGERY - DR KLI NE         70.06       09005       ORTHOPEDI C SURGERY - DR KLI NE         70.07       09007       FI RST CAPI TAL MEDI CAL GROUP         70.08       09008       SOUTH HARRI SON FAMI LY MEDI CI NE         70.09       09009       PAI N MANAGEMENT         70.10       09010       DERMATOLOGY         71.00       09100       EMRGENCY         72.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)         71.00       09100	0. 10568		-	
72.00       07200       IMPL. DEV. CHARGED TO PATI ENT         73.00       DRUGS CHARGED TO PATI ENTS         0UTPATI ENT SERVICE COST CENTERS         00.00       09000         CLINIC         90.01       O9000         CUO       09001         SENIOR CARE         90.02       GENERAL SURGERY         90.03       09003         9004       CORYDON MEDI CAL ASSOCIATES         90.04       09004         9005       ORTHOPEDI C SURGERY - DR KLINE         90.05       09005         9006       OBGYN - DR SAUER         90.07       FIRST CAPI TAL MEDI CAL GROUP         90.08       SOUTH HARRI SON FAMI LY MEDI CINE         90.09       PAI N MANAGEMENT         90.10       DERMATOLOGY         91.00       OP100         PERREGENCY         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART)         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART)         92.00       OP300         92.00       OP300         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART)         92.00       OP300         92.01       OP300         92.02       OP300      >	0. 55635		-	
73.00         D7300         DRUGS CHARGED TO PATIENTS           OUTPATIENT SERVICE COST CENTERS           90.00         09000         CLINIC           90.01         09001         SENIOR CARE           90.02         09002         GENERAL SURGERY           90.03         09003         HARRI SON CRAWFORD HEALTHCARE           90.04         09004         CORYDON MEDICAL ASSOCIATES           90.05         09050         ORTHOPEDIC SURGERY - DR KLINE           90.06         09006         OBGYN - DR SAUER           90.07         09007         FIRST CAPITAL MEDICAL GROUP           90.08         09008         SOUTH HARRISON FAMILY MEDICINE           90.09         09009         PAIN MANAGEMENT           90.10         OPINO EMERGENCY           91.00         09100         EMERGENCY           92.00         092000         DBSERVATION BEDS (NON-DISTINCT PART)           0THER REIMBURSABLE COST CENTERS         01HER REIMBURSABLE COST CENTERS	0. 45592			
OUTPATI ENT SERVICE COST CENTERS           90.00         09000         CLINIC           90.01         09001         SENIOR CARE           90.02         09002         GENERAL SURGERY           90.03         09003         HARRI SON CRAWFORD HEALTHCARE           90.04         09004         CORYDON MEDI CAL ASSOCIATES           90.05         09050         ORTHOPEDI C SURGERY - DR KLINE           90.06         09006         OBGYN - DR SAUER           90.07         09007         FIRST CAPI TAL MEDI CAL GROUP           90.08         09008         SOUTH HARRI SON FAMI LY MEDI CINE           90.09         09009         PAIN MANAGEMENT           90.10         OPINO EMERGENCY           92.00         092000         DBSERVATI ON BEDS (NON-DI STINCT PART)           0THER REI MBURSABLE COST CENTERS         09500	0. 32658			
90.00       09000       CLINIC         90.01       09001       SENIOR CARE         90.02       09002       GENERAL SURGERY         90.03       09003       HARRI SON CRAWFORD HEALTHCARE         90.04       09004       CORYDON MEDI CAL ASSOCIATES         90.05       09005       ORTHOPEDI C SURGERY - DR KLINE         90.06       09006       OBGYN - DR SAUER         90.07       09007       FIRST CAPI TAL MEDI CAL GROUP         90.08       09008       SOUTH HARRI SON FAMI LY MEDI CINE         90.09       09009       PAI N MANAGEMENT         90.10       09010       DEMRATOLOGY         91.00       09100       EMERGENCY         92.00       0BSERVATI ON BEDS (NON-DI STINCT PART)         0THER REI MBURSABLE COST CENTERS       00500         9500       AMBULANCE SERVICES	0. 32030	0	0	/3.0
90.01         09001         SENI OR CARE           90.02         09002         GENERAL SURGERY           90.03         09003         HARRI SON CRAWFORD HEALTHCARE           90.04         09004         CORYDON MEDI CAL ASSOCI ATES           90.05         09005         ORTHOPEDI C SURGERY - DR KLI NE           90.06         09006         0BGYN - DR SAUER           90.07         09007         FI RST CAPI TAL MEDI CAL GROUP           90.08         09008         SOUTH HARRI SON FAMI LY MEDI CI NE           90.09         PAI N MANAGEMENT           90.10         OPO10         DEMATOLOGY           91.00         OPO200         BESERVATI ON BEDS (NON-DI STI NCT PART)           92.00         0SERVATI ON BEDS (NON-DI STI NCT PART)           975.00         09500         AMBULANCE SERVI CES	0. 41287	70 0	0	90.0
20.02         09002         GENERAL SURGERY           20.03         09003         HARRI SON CRAWFORD HEALTHCARE           20.04         09004         CORYDON MEDI CAL ASSOCI ATES           20.05         09005         ORTHOPEDI C SURGERY - DR KLI NE           20.06         09006         OBGYN - DR SAUER           20.07         FIRST CAPI TAL MEDI CAL GROUP           20.08         09008         SOUTH HARRI SON FAMI LY MEDI CI NE           20.09         09009         PAI N MANAGEMENT           20.10         09010         EMRATOLOGY           21.00         09100         EMREGENCY           22.00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART)           0THER REI MBURSABLE COST CENTERS         00500	0. 76784			
900.03       09003       HARRI SON CRAWFORD HEALTHCARE         90.04       09004       CORYDON MEDI CAL ASSOCI ATES         90.05       09005       ORTHOPEDI C SURGERY - DR KLI NE         90.06       09006       OBGYN - DR SAUER         90.07       09007       FI RST CAPI TAL MEDI CAL GROUP         90.08       09008       SOUTH HARRI SON FAMI LY MEDI CI NE         90.09       09009       PAI N MANAGEMENT         90.10       OPHATOLOGY         91.00       09100         EMERGENCY         92.00       09SERVATI ON BEDS (NON-DI STI NCT PART)         0THER       REI MBURSABLE COST CENTERS	5. 41249			
20.04         09004         CORYDON MEDICAL ASSOCIATES           20.05         09005         ORTHOPEDIC SURGERY - DR KLINE           20.06         09006         0BGYN - DR SAUER           20.07         09007         FIRST CAPITAL MEDICAL GROUP           20.08         09008         SOUTH HARRISON FAMILY MEDICINE           20.09         09009         PAIN MANAGEMENT           20.10         09010         DERMATOLOGY           21.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)           0THER         REI MBURSABLE COST CENTERS           25.00         09500         AMBULANCE SERVICES	3. 50198			
200.05         09005         ORTHOPEDIC SURGERY - DR KLINE           200.06         09006         0BGYN - DR SAUER           200.07         09007         FIRST CAPITAL MEDICAL GROUP           200.08         09008         SOUTH HARRISON FAMILY MEDICINE           200.09         09009         PAIN MANAGEMENT           200.10         09010         DERMATOLOGY           201.00         09100         EMERGENCY           202.00         09SERVATION BEDS (NON-DISTINCT PART)           0THER REIMBURSABLE COST CENTERS         09500	0. 77350		-	
200.06         09006         0BGYN - DR SAUER           20.07         09007         FI RST CAPI TAL MEDI CAL GROUP           20.08         09008         SOUTH HARRI SON FAMI LY MEDI CI NE           20.09         09009         PAI N MANAGEMENT           20.10         09010         DERMATOLOGY           21.00         09100         EMERGENCY           22.00         092000         DBSERVATI ON BEDS (NON-DI STI NCT PART)           0THER         REI MBURSABLE COST CENTERS           25.00         09500         AMBULANCE SERVI CES	0. 82934		-	90.0
20.07         09007         FIRST CAPITAL MEDICAL GROUP           20.08         09008         SOUTH HARRISON FAMILY MEDICINE           20.09         09009         PAIN MANAGEMENT           20.10         09010         DERMATOLOGY           21.00         09100         EMERGENCY           22.00         092000         OBSERVATION BEDS (NON-DISTINCT PART)           0THER         REI MBURSABLE COST CENTERS           25.00         09500         AMBULANCE SERVICES	2. 09524		-	
20.08     09008     SOUTH HARRISON FAMILY MEDICINE       20.09     09009     PAIN MANAGEMENT       20.10     09010     DERMATOLOGY       20.10     09100     EMERGENCY       20.20     09200     OBSERVATION BEDS (NON-DISTINCT PART)       0THER REIMBURSABLE COST CENTERS     09500       295.00     09500	3. 88614			90.0
20.09         09009         PAIN         MANAGEMENT           20.10         09010         DERMATOLOGY           21.00         09100         EMERGENCY           22.00         09200         OBSERVATION           DTHER         REI MBURSABLE         COST           25.00         09500         AMBULANCE	4. 91044		-	
20. 10     09010     DERMATOLOGY       21. 00     09100     EMERGENCY       22. 00     09200     OBSERVATI ON BEDS (NON-DI STINCT PART)       0THER     REI MBURSABLE     COST       25. 00     09500     AMBULANCE	4. 91044 0. 26531			
021.00       09100       EMERGENCY         022.00       09200       OBSERVATI ON BEDS (NON-DISTINCT PART)         0THER       REI MBURSABLE       COST         25.00       09500       AMBULANCE			0	1
022.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)         0THER       REI MBURSABLE       COST         05.00       09500       AMBULANCE         05.00       09500       AMBULANCE	0. 63515 0. 14555			
OTHER         REI MBURSABLE         COST         CENTERS           25.00         09500         AMBULANCE         SERVI CES	1. 08334			
95. 00 09500 AMBULANCE SERVICES	1.00334	• 1] 0	0	92.0
				95.0
200 00 Llotal (sum of lines 50 through 94 and 96 through 99)		0		200.0
200.00Total (sum of lines 50 through 94 and 96 through 98)201.00Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		200.0
202.00 Net charges (line 200 minus line 201)		0		201.0

	Financial Systems HARRISON COUNTY			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Pre	
		Title XVIII	Hospi tal	5/31/2022 11: Cost	<u>29 am</u>
			•••••	1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			6, 951, 054	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	ctions)		0	
3.00 4.00	Outlier payment (see instructions)			0	
4.01	Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	1
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	
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	
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 6, 951, 054	10.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			0	10.00
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	line 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15 00	Customary charges			0	1 1 5 00
15.00 16.00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for			0	
10.00	had such payment been made in accordance with 42 CFR §413.13		on a ona gobasi s	Ū	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete or	nlvifline 18 exceeds l	ine 11) (see	0	
17.00	instructions)			Ū	
20.00	Excess of reasonable cost over customary charges (complete or	nly if line 11 exceeds l	ine 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			7, 020, 565	21.00
22.00	Interns and residents (see instructions)			0	1
23.00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	ns)		79, 755	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on lin			5, 721, 941	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 2	2 and 23] (see	1, 218, 869	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, I	line 50)		0	
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	)		0 1, 218, 869	
30.00 31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			1, 210, 809	
32.00	Subtotal (line 30 minus line 31)			1, 218, 725	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. I-5, line 11)	ICES)		0	33.00
	Allowable bad debts (see instructions)			749, 953	1
35.00	Adjusted reimbursable bad debts (see instructions)			487, 469	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (see instructions)	tructions)		428, 079 1, 706, 194	
38.00	MSP-LCC reconciliation amount from PS&R			1, 700, 174	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	ns)		0	39.50 39.97
39.97	Partial or full credits received from manufacturers for repla	aced devices (see instru	ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			1, 706, 194 0	
40.01	Demonstration payment adjustment amount after sequestration			0	
40.03	Sequestration adjustment-PARHM pass-throughs				40.03
41.00	Interim payments			2, 030, 441	
41.01 42.00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01 42.00
42.01	Tentative settlement-PARHM (for contractor use only)				42.01
43.00	Balance due provider/program (see instructions)			-324, 247	
43.01 44.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2	chapter 1.	262, 484	43.01 44.00
	§115. 2			202, 104	
00.00	TO BE COMPLETED BY CONTRACTOR			0	
90.00 91.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00 94.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00
74.00				0	J 74.00

	I Financial Systems HARRISON COUN SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	TY HOSPITAL Provider CO	CN: 15-1331	Peri od:	u of Form CMS-2 Worksheet E-1	
				From 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre 5/31/2022 11:	
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount		Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		2, 785, 8	83	1, 390, 941	1
00	Interim payments payable on individual bills, either			0	0	2
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3
00	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER	09/30/2021	662, 8		639, 500	3
2				0	0	
)3 )4				0	0	
)4 )5				0	0	
00	Provider to Program			0	0	
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		662, 8	00	639, 500	3
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		3, 448, 6	83	2, 030, 441	4
00	(transfer to Wkst. E or Wkst. E-3, line and column as		3, 440, 0	00	2,030,441	
	appropri ate)					
	TO BE COMPLÉTED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
D1	TENTATI VE TO PROVIDER			0	0	ļ
02				0	0	Ę
03				0	0	Ę
	Provider to Program				1	
50	TENTATI VE TO PROGRAM			0	0	Ę
51				0	0	5
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
77	5. 50-5. 98)			U		
00	Determined net settlement amount (balance due) based on					6
-	the cost report. (1)					
01	SETTLEMENT TO PROVIDER			0	0	6
02	SETTLEMENT TO PROGRAM		117, 6		324, 247	6
00	Total Medicare program liability (see instructions)		3, 331, 0		1, 706, 194	
				Contractor	NPR Date	
			)	Number 1.00	(Mo/Day/Yr) 2.00	
00	Name of Contractor	l	,	1.00	2.00	6

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CC Component (		Period: From 01/01/202 To 12/31/202		epare
		Title	XVIII	Swing Beds - SN		27 0
		I npati en			nrt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	-
		1.00	2.00	3. 00	4.00	-
00	Total interim payments paid to provider		145, 0		0	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
~~	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVI DER	09/30/2021	36, 6	00	0	3
)2				0	0	3
)3				0	0	3
)4				0	0	3
)5				0	0	3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52				0	0	
53 54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		36, 6	-	0	
77	3. 50-3. 98)		50, 0	00	0	
00	Total interim payments (sum of lines 1, 2, and 3.99)		181, 6	56	0	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
)1	TENTATI VE TO PROVIDER			0	0	1
)2				0	0	
)3				0	0	
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	Ę
51				0	0	
52				0	0	1 7
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
~	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		45, 0	47	0	6
)2	SETTLEMENT TO PROGRAM		43,0	0	0	
00	Total Medicare program liability (see instructions)		226, 7	0	0	
-			/	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1.00	2.00	

Heal th	Financial Systems HARRISON COUN	TY HOSPI TAL	In Lie	u of Form CMS-	2552-10		
CALCU	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1331 Period: W From 01/01/2021 P To 12/31/2021 5						
		Title XVIII	Hospi tal	Cost			
				1.00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI						
1.00	Total hospital discharges as defined in AARA §4102 from Wks				1.00		
2.00							
	reporting periods beginning on or after 10/01/2013, line 32)						
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2						
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of line reporting periods beginning on or after 10/01/2013, line 32		d plus for cost		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 line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00		
8.00	Calculation of the HIT incentive payment (see instructions)				8.00		
9.00							
10.00	Calculation of the HIT incentive payment after sequestration	on (see instructions)			10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH						
30.00	30.00 Initial/interim HIT payment adjustment (see instructions)						
31.00							
32.00	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)						

alth Financial Systems LCULATION OF REIMBURSEMENT SETTLEMENT - SWING B	EDS Provider CCN: 15-1331	Peri od:	u of Form CMS-: Worksheet E-2	
	Component CCN: 15-Z331	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/31/2022 11:	epareo 29 ar
	Title XVIII	Swing Beds - SNF	Cost	
		Part A 1.00	Part B 2.00	
COMPUTATION OF NET COST OF COVERED SERVICES			21.00	
00 Inpatient routine services - swing bed-SNF (		191, 417	0	
00 Inpatient routine services - swing bed-NF (s		00.054		2.
00 Ancillary services (from Wkst. D-3, col. 3, Part V, cols. 6 and 7, line 202, for Part B)			0	3.
instructions)				
01 Nursing and allied health payment-PARHM (see	e instructions)			3.
00 Per diem cost for interns and residents not	in approved teaching program (see		0.00	4.
instructions) 00 Program days		84	0	5.
00 Interns and residents not in approved teachi	ina proaram (see instructions)	04	0	
00 Utilization review - physician compensation		0		7.
00 Subtotal (sum of lines 1 through 3 plus line	es 6 and 7)	229, 671	0	
00 Primary payer payments (see instructions) .00 Subtotal (line 8 minus line 9)		0	0	
.00 Subtotal (line 8 minus line 9) .00 Deductibles billed to program patients (excl	lude amounts applicable to physician	229, 671	0	
professional services)	rude amounts appricable to physician	0	0	'''
.00 Subtotal (line 10 minus line 11)		229, 671	0	12.
.00 Coinsurance billed to program patients (from	m provider records) (exclude coinsurance	2, 968	0	13.
for physician professional services) .00 80% of Part B costs (line 12 x 80%)			0	14.
. 00 Subtotal (see instructions)		226, 703	0	
. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIF	FY)	0	0	
. 50 Pioneer ACO demonstration payment adjustment				16.
.55 Rural community hospital demonstration proje	ect (§410A Demonstration) payment	0		16.
adjustment (see instructions) .99 Demonstration payment adjustment amount befo	ore sequestration	0	0	16.
. 00 Allowable bad debts (see instructions)		0	0	
.01 Adjusted reimbursable bad debts (see instruc		0	0	
.00 Allowable bad debts for dual eligible benefi	iciaries (see instructions)	0	0	
.00 Total (see instructions) .01 Sequestration adjustment (see instructions)		226, 703 0	0	
. 02 Demonstration payment adjustment amount after	er seguestration)	0	0	
. 03 Sequestration adjustment-PARHM pass-throughs		-	_	19.
. 25 Sequestration for non-claims based amounts (	(see instructions)	0	0	
. 00 Interim payments		181, 656	0	
.01  Interim payments-PARHM .00  Tentative settlement (for contractor use onl		0	0	20.
.01 Tentative settlement-PARHM (for contractor u		0	0	21.
.00 Balance due provider/program (line 19 minus	lines 19.01, 19.02, 19.25, 20, and 21)	45, 047	0	22.
. 01 Balance due provider/program-PARHM (see inst				22.
.00 Protested amounts (nonallowable cost report chapter 1, §115.2	items) in accordance with CMS Pub. 15-2,	0	0	23.
Rural Community Hospital Demonstration Proje	ect (§410A Demonstration) Adjustment			1
0.00 Is this the first year of the current 5-year				200.
Century Cures Act? Enter "Y" for yes or "N"	for no.			-
Cost Reimbursement 1.00 Medicare swing-bed SNF inpatient routine ser	rvice costs (from Wkst D-1 Pt II line	<u></u>		201.
66 (title XVIII hospital))		·		201.
2.00 Medicare swing-bed SNF inpatient ancillary s	service costs (from Wkst. D-3, col. 3, li	ne		202.
200 (title XVIII swing-bed SNF))				
3.00 Total (sum of lines 201 and 202) 4.00 Medicare swing-bed SNF discharges (see instr	ructions)			203. 204.
Computation of Demonstration Target Amount L		ent 5-year demons	tration	204.
period)	、			
5.00 Medicare swing-bed SNF target amount				205.
6.00 Medicare swing-bed SNF inpatient routine cos Adjustment to Medicare Part A Swing-Bed SNF				206.
7.00 Program reimbursement under the §410A Demons				207.
8.00 Medicare swing-bed SNF inpatient service cos	· · ·	5 1		208
and 3)				
9.00 Adjustment to Medicare swing-bed SNF PPS pay	yments (see instructions)			209.
0.00 Reserved for future use Comparision of PPS versus Cost Reimbursement				210.
5.00 Total adjustment to Medicare swing-bed SNF F		2		215.

CULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Period:	Worksheet E-	-2
		From 01/01/2021 To 12/31/2021	Date/Time Pr 5/31/2022 11	
	Title XIX	Swing Beds - SNF		
		Part A 1.00	<u>Part B</u> 2.00	
COMPUTATION OF NET COST OF COVERED SERVICES			21.00	
D Inpatient routine services - swing bed-SNF (see instructi		0		1
D Inpatient routine services - swing bed-NF (see instructio		0		2
Ancillary services (from Wkst. D-3, col. 3, line 200, for Part V, cols. 6 and 7, line 202, for Part B) (For CAH and		0		3
instructions)	swing-bed pass-through, see			
Nursing and allied health payment-PARHM (see instructions	)			3
) Per diem cost for interns and residents not in approved t	eaching program (see	0.00		4
instructions)		_		_
) Program days	an instructions)	0		5
<ul> <li>Interns and residents not in approved teaching program (s</li> <li>Utilization review - physician compensation - SNF optiona</li> </ul>		0		6
Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	i metrioù orn y	0		8
<ul> <li>Primary payer payments (see instructions)</li> </ul>		0		9
00 Subtotal (line 8 minus line 9)		0		10
DO Deductibles billed to program patients (exclude amounts a	pplicable to physician	0		11
professional services)				
00  Subtotal (line 10 minus line 11) 00  Coinsurance billed to program patients (from provider rec		0		12
00 Coinsurance billed to program patients (from provider rec for physician professional services)	ords) (exclude collisurance	0		13
00 80% of Part B costs (line 12 x 80%)		0		14
00 Subtotal (see instructions)		0		15
OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16
50 Pioneer ACO demonstration payment adjustment (see instruc	tions)			16
55 Rural community hospital demonstration project (§410A Dem	onstration) payment			16
adjustment (see instructions)				
P9 Demonstration payment adjustment amount before sequestrat 00 Allowable bad debts (see instructions)	I ON	0		16
00 Allowable bad debts (see instructions) 01 Adjusted reimbursable bad debts (see instructions)		0		17
00 Allowable bad debts for dual eligible beneficiaries (see	instructions)	0		18
00 Total (see instructions)		0		19
01 Sequestration adjustment (see instructions)		0		19
D2 Demonstration payment adjustment amount after sequestrati	on)	0		19
03 Sequestration adjustment-PARHM pass-throughs		_		19
25 Sequestration for non-claims based amounts (see instructi	ons)	0		19
00  Interim payments 01  Interim payments-PARHM		0		20
DO Tentative settlement (for contractor use only)		0		20
D1 Tentative settlement-PARHM (for contractor use only)		Ŭ		21
DO Balance due provider/program (line 19 minus lines 19.01,	19.02, 19.25, 20, and 21)	0		22
D1 Balance due provider/program-PARHM (see instructions)				22
00 Protested amounts (nonallowable cost report items) in acc	ordance with CMS Pub. 15-2,	0		23
chapter 1, §115.2	anatzatian) Adiyatzant			_
Rural Community Hospital Demonstration Project (§410A Dem 00 Is this the first year of the current 5-year demonstratio	n period under the 21st			200
Century Cures Act? Enter "Y" for yes or "N" for no.				1200
Cost Reimbursement				
00 Medicare swing-bed SNF inpatient routine service costs (f	rom Wkst. D-1, Pt. II, line			201
66 (title XVIII hospital))				0.0-
00 Medicare swing-bed SNF inpatient ancillary service costs	(Trom Wkst. D-3, col. 3, lin	e		202
200 (title XVIII swing-bed SNF)) 00 Total (sum of lines 201 and 202)				203
00 Medicare swing-bed SNF discharges (see instructions)				203
Computation of Demonstration Target Amount Limitation (N/	A in first year of the curre	nt 5-year demons	tration	
period)				
00 Medicare swing-bed SNF target amount				205
00 Medicare swing-bed SNF inpatient routine cost cap (line 2				206
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Rei 00 Program reimbursement under the §410A Demonstration (see				207
00 Medicare swing-bed SNF inpatient service costs (from Wkst	-	1		207
and 3)	,			
00 Adjustment to Medicare swing-bed SNF PPS payments (see in	structions)			209
00 Reserved for future use				210
Comparision of PPS versus Cost Reimbursement				-
00 Total adjustment to Medicare swing-bed SNF PPS payment (I instructions)	ine 209 plus line 210) (see			215

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Pre	epar
		Title XVIII	Hospi tal	5/31/2022 11: Cost	29
			nospi tui	0031	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIC	CARE PART A SERVICES - COS	ST REIMBURSEMENT		
00	Inpatient services			3, 566, 863	1
00	Nursing and Allied Health Managed Care payment (see instru	uctions)		0	2
00	Organ acquisition			0	
00	Subtotal (sum of lines 1 through 3)			3, 566, 863	
00	Primary payer payments			0	1 7
00	Total cost (line 4 less line 5). For CAH (see instructions	5)		3, 602, 532	6
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable charges			0	Ι.
00 00	Routine service charges Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
. 00	Total reasonable charges			0	
. 00	Customary charges				1
. 00	Aggregate amount actually collected from patients liable f	for payment for services or	n a charge basis	0	1 11
. 00	Amounts that would have been realized from patients liable			0	
	had such payment been made in accordance with 42 CFR 413.1	13(e)	5		
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	13
. 00	Total customary charges (see instructions)			0	14
. 00	Excess of customary charges over reasonable cost (complete	e only if line 14 exceeds l	ine 6) (see	0	15
	instructions)				
5.00	Excess of reasonable cost over customary charges (complete	e only if line 6 exceeds li	ne 14) (see	0	16
,	instructions)			0	1.
7.00	Cost of physicians' services in a teaching hospital (see i COMPUTATION OF REIMBURSEMENT SETTLEMENT	nstructions)		0	17
3. 00	Direct graduate medical education payments (from Worksheet	t E 4 lino 40)		0	118
9.00	Cost of covered services (sum of lines 6, 17 and 18)			3, 602, 532	
. 00	Deductibles (exclude professional component)			290, 348	
. 00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21)			3, 312, 184	
3.00	Coinsurance			13, 727	
. 00	Subtotal (line 22 minus line 23)			3, 298, 457	24
5.00	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)	)	50, 145	25
5.00	Adjusted reimbursable bad debts (see instructions)			32, 594	26
7.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		11, 412	27
3.00	Subtotal (sum of lines 24 and 25, or line 26)			3, 331, 051	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see instruct	tions)		0	
. 98	Recovery of accelerated depreciation.			0	1 -
9.99	Demonstration payment adjustment amount before sequestrati	on		0	
0.00	Subtotal (see instructions)			3, 331, 051	
0.01	Sequestration adjustment (see instructions)			0	
). 02 ). 03	Demonstration payment adjustment amount after sequestratic Sequestration adjustment-PARHM	ווכ		0	30
. 00	Interim payments			3, 448, 683	
. 00	Interim payments-PARHM			5, 440, 005	31
2.00	Tentative settlement (for contractor use only)			0	32
2. 01	Tentative settlement-PARHM (for contractor use only)			0	32
3.00	Balance due provider/program (line 30 minus lines 30.01, 3	30,02,31, and 32)		-117, 632	
3. 01	Bal ance due provi der/program-PARHM (lines 2, 3, 18, and 26		1, and 32.01)	, 302	33
				17, 551	
. 00	Protested amounts (nonallowable cost report items) in acco	JI UANCE WITTI CWS FUD. 13-2,	chapter I, I	17, 551	

Display         Contrait         Fund         Second Tool         Endowed Plant Fund           0         Cash on hand in backs         9, 484,097         0		E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		eriod: com 01/01/2021 ) 12/31/2021	Worksheet G Date/Time Pre	pared:
CluberNL ASSETS         1.00         2.00         3.00         4.00           1.00         Cash on hand in banks         9.44.097         0	on y)		General Fund			5/31/2022 11:	
1.00         Cash on hand in banks         9, 444, 097         0         0           2.00         Imaginary investments         6, 38, 288         0         0         0           3.00         Accounts receivable         24, 088, 550         0         0         0           3.00         Intersence value         1, 99, 283         0         0         0           4.00         Intersence value         1, 99, 283         0         0         0           5.00         Intersence value         1, 99, 283         0         0         0           6.00         Propaid expenses         764, 390         0         0         0         0           7.00         Intersence value         3, 300, 138         0         0         0         0           7.10         Intersence value         3, 303, 138         0         0         0         0           7.00         Buil dings percel ation         -2, 652, 449         0 <td< th=""><th></th><th></th><th>1.00</th><th></th><th></th><th>4.00</th><th></th></td<>			1.00			4.00	
2.00         Temporary investments         6.36, 208         0         0           0.00         Metser servivable         0         0         0           0.01         Metservivable         0         0         0           0.00         Metservivable         0         0         0         0           0.00         Metservivable         754, 390         0         0         0           0.00         Metservivable         3, 355, 874         0         0         0           11.00         Accumulated depreciation         -2, 53, 944         0         0         0           12.00         Accumulated depreciation         -2, 54, 94         0         0         0           12.00         Accumulated depreciation         -2, 54, 94         0         0         0           12.00         Accumulated depreciation         -2, 54, 94         0         0         0         0           12.00	1.00		9, 484, 097	0	0	0	1.00
4.00         Accounts receivable         24,009,536         0         0           0.00         Netrocelvable         1,293,03         0         0           0.00         Inventory         19,059,427         0         0           0.00         Prepaid expenses         194,500         0         0         0           0.00         Discontents         54,300         0         0         0           0.00         Discontents         54,300         0         0         0           0.01         Inventory         3,001,381         0         0         0           11.00         Dadi Improvements         3,001,381         0         0         0           12.00         Land         3,001,381         0         0         0         0           13.00         Accumulated depreciation         -2,052,449         0         0         0           10.00         Accumulated depreciation         -2,052,449         0					-	0	
5.00         Other receivable         1,293,203         0         0           7.00         Inventors for uncollectible notes and accounts receivable         1,399,283         0         0           7.00         Inventory         1,399,283         0         0         0           0.00         Other current assets         754,390         0         0         0           0.00         Other context funds         10,480,582         0         0         0           1.00         Dard casters assets (sum of lines 1-10)         10,480,582         0         0         0           1.00         Iand improvements         3,358,376         0         0         0         0           1.00         Iand         Iangrowents         575,33,961         0         0         0           1.00         Accound tact depreciation         -760,771         0			0	0	0	0	3.00
6.00         All lowances for uncollectible notes and accounts receivable         -19, 058, 427         0         0           7.00         Investory         880, 392         0         0           0.00         Other current assets         754, 390         0         0           0.00         Other current assets         754, 390         0         0           0.00         Diver from other funds         3, 001, 138         0         0           0.00         Diver from other funds         3, 001, 138         0         0           0.00         Diver from other funds         3, 001, 138         0         0           12.00         Land         10, 30, 138         0         0         0           12.00         Land         10, 30, 138         0         0         0         0           12.00         Land         10, 30, 138         0					0	0	4.00
7.00       Inventory       1, 399, 283       0       0         9.00       Other current assets       754, 390       0       0         9.00       Diter current assets       754, 390       0       0         11.00       Total current assets       3, 355, 876       0       0       1         12.00       Land       7, 644, 364       0       0       1         13.00       Lassets       255, 374       0       0       1         10.00       Lessehol 1 improvements       857, 722       0       0       1         10.00       Accurulated depreciation       -760, 271       0					0	0	5.00
8.00         Prepaid expenses         880, 292         0         0           0.00         Determentser funds         0         0         0           10.00         Due from other funds         0         0         0           10.00         Determent assets (sun of lines 1-10)         19, 480, 582         0         0           12.00         Land         Land metrovenents         3, 201, 138         0         0           13.00         Land metrovenents         3, 255, 774         0         0         0           14.00         Maccumulated depreciation         -25, 133, 941         0         0         0           16.00         Accumulated depreciation         -760, 271         0         0         0           17.00         Leasehold improvenents         0         0         0         0           10.01         Accumulated depreciation         28, 128, 100         0         0         0           20.00         Accumulated depreciation         28, 128, 100         0         0         0         0           20.01         Accumulated depreciation         0         0         0         0         0         0         0           20.01         Accumulated deprecia					0	0	7.00
0.00         Due from other funds         0         0         0           10.00         Due from other funds         0         0         0           11.00         Total current assets (sum of lines 1-10)         19,480,582         0         0           11.00         Land improvements         3, 355,976         0         0         1           12.00         Land improvements         3, 255,976         0         0         1           13.00         Laxed indepreciation         -2, 652,449         0         0         1           15.00         Maccinulated depreciation         -760,271         0         0         1           10.01         Leasehold inprovements         -857,727         0	8.00	Prepai d'expenses	880, 292	0	0	0	8.0
11.00         Total current assets (sum of lines 1-10)         19,480,582         0         0           12.00         Land         3,001,138         0         0         1           12.00         Land         3,001,138         0         0         1           12.00         Land improvements         3,355,876         0         0         1           13.00         Land improvements         25,133,941         0         0         1           10.01         Lage depreciation         -26,62,449         0         0         1           10.02         Lage depreciation         -26,62,494         0         0         1           10.02         Lage depreciation         -26,73,941         0         0         1           10.02         Lage depreciation         -26,74         0         0         0         1           10.02         Accurulated depreciation         -28,128,109         0         0         1         1           21.00         Accurulated depreciation         -26,436,480         0         0         1         1           22.00         Accurulated depreciation         0         0         0         0         1         1         1 <td< td=""><td></td><td></td><td>754, 390</td><td></td><td>-</td><td>0</td><td></td></td<>			754, 390		-	0	
FIED ASSETS         Image: Constraint of the second se			10, 400, 500	-	-	0	10.0
12.00       Land       3.001, 138       0       0         13.00       Land laprovements       3.355, 876       0       0         14.00       Accumul ated depreciation       -2, 652, 449       0       0         15.00       Ruil dings       37, 464, 364       0       0         16.00       Accumul ated depreciation       -25, 133, 941       0       0         17.00       Lasschold improvements       875, 722       0       0         18.00       Accumul ated depreciation       -760, 271       0       0       0         18.00       Accumul ated depreciation       -26, 124, 04       0       0       0         20.00       Accumul ated depreciation       -26, 246, 480       0       0       0         21.00       Accumul ated depreciation       -25, 436, 480       0       0       0       0         21.00       Accumul ated depreciation       -25, 436, 480       0       0       0       0       0       0         22.00       Accumul ated depreciation       -25, 436, 480       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       <	11.00		19, 480, 582	0	0	0	11.0
13.00       Land improvements       3.355, 876       0       0         14.00       Accumulated depreciation       -2.652, 449       0       0         15.00       Buildings       37, 464, 364       0       0         15.00       Buildings       37, 464, 364       0       0         15.00       Lassehol I improvements       857, 272       0       0         16.00       Accumulated depreciation       -760, 271       0       0         17.00       Lassehol I improvements       0       0       0         19.00       Fixed equipment       346, 074       0       0       0         19.00       Fixed equipment       28, 128, 109       0       0       0       0         21.00       Automobiles and trucks       0	12.00		3, 001, 138	0	0	0	12.00
15.00         Buildings         37, 464, 364         0         0           15.00         Accumulated depreciation         -25, 133, 941         0         0           17.00         Leasehold improvements         857, 272         0         0           10.00         Fixed equipment         346, 074         0         0           17.00         Itemprovements         0         0         0           17.00         Accumulated depreciation         0         0         0           17.00         Atomobiles and trucks         0         0         0         0           20.0         Accumulated depreciation         25, 436, 480         0         0         0           21.00         Major movable equipment         28, 128, 109         0         0         0           22.00         Major movable equipment         28, 128, 109         0         0         0           22.01         Major movable equipment         28, 128, 109         0         0         0           23.00         Major movable equipment         29, 129, 109, 602         0         0         0           24.00         Accumulated depreciation         0         0         0         0         0 <t< td=""><td></td><td></td><td></td><td></td><td>-</td><td>0</td><td>13.00</td></t<>					-	0	13.00
16.00       Accumulated depreciation       -25.133.941       0       0         17.00       Leasehold improvements       857.272       0       0         18.00       Accumulated depreciation       -760.271       0       0         18.01       Accumulated depreciation       -760.271       0       0         20.00       Accumulated depreciation       0       0       0         21.00       Accumulated depreciation       0       0       0         22.00       Accumulated depreciation       -25.436.480       0       0         23.00       Major movable equipment       28.128.109       0       0       0         24.00       Accumulated depreciation       0       0       0       0         25.00       Mior equipment chasts       0       0       0       0         26.00       Accumulated depreciation       0       0       0       0       0         26.00       Accumulated depreciation       0       0       0       0       0       0         27.00       HT fixed assets (sum of lines 12-29)       19.169.692       0       0       0       0         20.00       Depopristson leases       7.172       0	14.00	Accumulated depreciation	-2, 652, 449	0	0	0	14.00
17.00       Leasehol d imprivements       857,272       0       0         18.00       Accumulated depreciation       -760,271       0       0         19.00       Fixed equipment       346,074       0       0         19.00       Fixed equipment       346,074       0       0         20.00       Accumulated depreciation       0       0       0         21.01       Automobiles and trucks       0       0       0         22.01       Accumulated depreciation       -25,436,480       0       0         23.00       Major movable equipment       28,128,109       0       0       0         25.00       Minor equipment, depreciable       0       0       0       0         26.00       Minor equipment, depreciable       0       0       0       0         27.00       Minor equipment-nondepreciable       0       0       0       0         27.00       Minor equipment-nondepreciable       0       0       0       0       0         28.00       Deposits no leases       7,423,497       0       0       0       0       0         20.00       Deposits no leases       1,720       0       0       0 <td></td> <td></td> <td></td> <td></td> <td>Ű</td> <td>0</td> <td></td>					Ű	0	
18. to Accumulated depreciation         -760, 271         0         0         1           19. to Fixed equipment         346, 074         0         0         0           20. to Accumulated depreciation         0         0         0         0           20. Accumulated depreciation         0         0         0         0           21. 00 Accumulated depreciation         -25, 436, 480         0         0         0           20. 00 Major equipment depreciation         0         0         0         0         0           20. 00 Major equipment depreciation         0         0         0         0         0         0           20. 01 Mi or equipment depreciation         0					Ű	0	16.00
19.00       Fixed equipment       346,074       0       0         19.00       Accumulated depreciation       0       0       0         21.00       Accumulated depreciation       0       0       0         21.00       Accumulated depreciation       0       0       0         21.00       Accumulated depreciation       -25,436,480       0       0         22.00       Accumulated depreciation       -25,436,480       0       0         23.00       Minor equipment depreciation       -25,436,480       0       0       0         25.00       Minor equipment-nondepreciation       0       0       0       0       0         27.00       HIT designated Assets       0       0       0       0       0       0         27.00       Minor equipment-nondepreciation       0       0       0       0       0       0         27.00       Minor equipment-fixed assets       7,423,497       0       0       0       0       0         20.01       Deposits on leases       -1,720       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0					0	0	17.00
20.00         Accumulated depreciation         0         0         0           21.00         Accumulated depreciation         0         0         0           22.00         Accumulated depreciation         0         0         0           23.00         Major movable e quipment         28.128.109         0         0           24.00         Accumulated depreciation         -25.436.480         0         0           24.00         Accumulated depreciation         0         0         0         0           25.00         Minor equipment depreciation         0         0         0         0           26.00         Minor equipment-nondepreciable         0         0         0         0           27.00         Minor equipment-nondepreciable         0         0         0         0           27.00         Minor equipment-nondepreciable         0         0         0         0           27.00         Minor equipment-systems         7,423,497         0         0         0           37.00         Depreciation         -1,720         0         0         0         0           38.00         Other assets         1,1,20, and 35)         46,072,051         0         0 <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td>19.00</td>					0	0	19.00
22.00         Accumulated depreciation         0         0         0           22.00         Major movable equipment         28.128.109         0         0           24.00         Accumulated depreciation         -25,436,480         0         0           24.00         Accumulated depreciation         -25,436,480         0         0           25.00         Minor equipment depreciable         0         0         0           27.00         Minor equipment-inondepreciable         0         0         0           27.00         Minor equipment-inondepreciable         0         0         0           27.00         Minor equipment-inondepreciable         0         0         0         0           27.00         Minor equipment fixed assets         (sum of lines 12-29)         19,169,692         0         0           37.00         Deposits on leases         0         0         0         0         0           38.00         Detrom owners/officers         -1,720         0         0         0         0           38.00         Detrom ownes/officers         -2,956,936         0         0         0         0           39.00         Payroli taxes payable         2,925,958,936 <td< td=""><td></td><td></td><td>0</td><td></td><td>0</td><td>0</td><td>20.00</td></td<>			0		0	0	20.00
23.00       kaj or movable equipment       28, 128, 109       0       0         24.00       Accumulated depreciation       -25, 436, 480       0       0         25.00       Minor equipment depreciation       0       0       0         26.00       Accumulated depreciation       0       0       0       0         27.00       Minor equipment nondepreciable       0       0       0       0         27.00       Minor equipment nondepreciable       0       0       0       0         20.01       filt designated Assets       0       0       0       0       0         20.02       Deposits on leases       7,423,497       0       0       0       0         20.02       Due from owners/officers       0       0       0       0       0         21.00       Total other assets (sum of lines 31-34)       7,421,477       0       0       0       0         20.00       Deposits on leases       -1,720       0 <td></td> <td></td> <td>0</td> <td>-</td> <td>0</td> <td>0</td> <td>21.00</td>			0	-	0	0	21.00
24.00       Accumulated depreciation       -25,436,480       0       0       0         25.00       Minor equipment depreciation       0       0       0       0         26.00       Minor equipment Assets       0       0       0       0       0         27.00       Hir designated Assets       0       0       0       0       0       0       0         27.00       Minor equipment Inondepreciation       0<			0	-	0	0	
25.00       Minor equipment depreciation       0       0       0         26.00       Accumulated depreciation       0       0       0         27.00       HIT designated Assets       0       0       0         28.00       Accumulated depreciation       0       0       0       0         28.00       Accumulated depreciation       0       0       0       0       0         28.00       Accumulated depreciation       0       0       0       0       0       0         20.00       Investments       0       0       0       0       0       0       0         31.00       Due from owners/officers       0       0       0       0       0       0       0         32.00       Deposits on leases       7,421,777       0 <t< td=""><td></td><td></td><td></td><td></td><td>0</td><td>0</td><td>23.00</td></t<>					0	0	23.00
26.00         Accumulated depreciation         0         0         0         0           27.00         HIT designated Assets         0         0         0         0         0           28.00         Accumulated depreciation         0         0         0         0         0           29.00         Minor equipment-nondepreciable         0			-25, 436, 480		-	0	24.0 25.0
27.00       HIT designated Assets       0       0       0         28.00       Accumulated depreciation       0       0       0         29.01       Minor equipment-nondepreciable       0       0       0       0         0       Ottat fixed assets (sum of lines 12-29)       19,169,692       0       0       0       0         0       Investments       7,423,497       0       0       0       0       0         31.00       Investments       0       0       0       0       0       0       0         32.00       Due from owners/officers       0			Ő	-	Ű	0	26.0
29.00       Winor equipment-nondepreciable       0       0       0         30.00       Total fixed assets (sum of lines 12-29)       19, 169, 692       0       0         01       Investments       7, 423, 497       0       0         31.00       Deposits on leases       0       0       0         32.00       Deposits on leases       0       0       0         33.00       Due from owners/officers       0       0       0         34.00       Other assets (sum of lines 31-34)       7, 421, 777       0       0         05       Total other assets (sum of lines 31-34)       7, 421, 777       0       0       0         06       Total assets (sum of lines 31-34)       7, 421, 777       0       0       0       0         07       DA cocurts payable       2, 912, 967       0       0       0       0       0         08       Salaries, wages, and fees payable       2, 912, 967       0			0	0	0	0	27.00
30.00         Total fixed assets (sum of lines 12-29)         19, 169, 692         0         0           31.00         Investments         7, 423, 497         0         0         0           32.00         Deposits on leases         0         0         0         0           32.00         Other assets         -1, 720         0         0         0           30.00         Other assets (sum of lines 31-34)         7, 421, 777         0         0         0           30.00         Total assets (sum of lines 31-34)         7, 421, 777         0         0         0           30.00         Current Lines 11, 30, and 35)         46, 072, 051         0         0         0           30.00         Current seavable         2, 956, 936         0         0         0         0           30.00         Deprival taxes payable         2, 212, 967         0         0         0         0           31.00         Decounts payable (short term)         0			0	0	0	0	28.00
OTHER ASSETS         Investments         7,423,497         0         0         0           31.00         Deposits on leases         0         <			0		-	0	29.00
31.00       Investments       7, 423, 497       0       0         32.00       Deposits on leases       0       0       0         32.00       Due from owners/officers       0       0       0         33.00       Due from owners/officers       0       0       0       0         34.00       Other assets       -1,720       0       0       0         35.00       Total other assets (sum of lines 31-34)       7,421,777       0       0       0         36.00       Total assets (sum of lines 11, 30, and 35)       46,072,051       0       0       0         7.00       Accounts payable       2,212,967       0       0       0       0         37.00       Accounts payable       0       0       0       0       0         8.00       Salaries, wages, and fees payable       2,956,936       0       0       0       0         9.00       Payrol1 taxes payable       0	30.00		19, 169, 692	0	0	0	30.00
32.00       Deposits on leases       0       0       0         33.00       Due from owners/officers       0       0       0         33.00       Due from owners/officers       0       0       0         33.00       Total other assets (sum of lines 31-34)       7, 421, 777       0       0         35.00       Total assets (sum of lines 11, 30, and 35)       46, 072, 051       0       0         CURRENT LIABILITIES       2, 212, 967       0       0       0         37.00       Accounts payable       2, 212, 967       0       0       0         38.00       Salaries, wages, and fees payable       2, 956, 936       0       0       0         39.00       Payrol1 taxes payable (short term)       0       0       0       0       0         41.00       Deferred income       0       0       0       0       0       0         42.00       Accelerated payments       0       0       0       0       0       0         43.00       Due to other funds       6, 965, 238       0       0       0       0       0         46.00       Mortgage payable       3, 952, 558       0       0       0       0       0 </td <td>31.00</td> <td></td> <td>7, 423, 497</td> <td>0</td> <td>0</td> <td>0</td> <td>31.00</td>	31.00		7, 423, 497	0	0	0	31.00
34.00       Other assets       -1,720       0       0         35.00       Total other assets (sum of lines 31-34)       7,421,777       0       0       0         60.00       Total assets (sum of lines 11, 30, and 35)       46,072,051       0       0       0         CURRENT LLABLLTIES       -       -       0       0       0       0       0         37.00       Accounts payable       2,212,967       0 </td <td>32.00</td> <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td>32.00</td>	32.00				0	0	32.00
35.00       Total other assets (sum of lines 31-34)       7, 421, 777       0       0         36.00       Total assets (sum of lines 11, 30, and 35)       46, 072, 051       0       0         CURRENT LIABLITIES			0	0	U.S.	0	33.00
36.00         Total assets (sum of lines 11, 30, and 35)         46,072,051         0         0           CURRENT LIABILITIES					Ű	0	34.00
CURRENT LIABILITIES         2,212,967         0         0           37.00         Accounts payable         2,212,967         0         0         0           38.00         Salaries, wages, and fees payable         2,956,936         0         0         0           39.00         Payroll taxes payable (short term)         0         0         0         0         0           40.00         Notes and loans payable (short term)         0		Total assets (sum of lines 11, 30, and 35)			-	0	35.00
37.00       Accounts payable       2,212,967       0       0         38.00       Salaries, wages, and fees payable       2,956,936       0       0         39.00       Payroll taxes payable       0       0       0         40.00       Notes and loans payable (short term)       0       0       0         00       Deferred income       0       0       0       0         41.00       Deferred income       0       0       0       0         42.00       Accelerated payments       0       0       0       0         43.00       Due to other funds       0       0       0       0         43.00       Other current liabilities       6,965,238       0       0       0         45.00       Total current liabilities       6,965,238       0       0       0         10NG TERM LIABILITIES       0       0       0       0       0       0         46.00       Mortes payable       0       0       0       0       0       0         47.00       Notes payable       3,952,558       0       0       0       0       0         48.00       Unsecured loans       0       0	30.00		40, 072, 031	0	0	0	30.00
39.00       Payrol I taxes payable       0       0       0         40.00       Notes and Ioans payable (short term)       0       0       0         41.00       Deferred income       0       0       0         42.00       Accel erated payments       0       0       0         43.00       Due to other funds       0       0       0         43.00       Other current liabilities       6,965,238       0       0         45.00       Total current liabilities (sum of lines 37 thru 44)       12,135,141       0       0         100       Total current liabilities       3,952,558       0       0       0         46.00       Mortgage payable       3,952,558       0       0       0         48.00       Unsecured loans       0       0       0       0         49.00       Other long term liabilities       0       0       0       0         50.00       Total liabilities (sum of lines 46 thru 49)       3,952,558       0       0       0         6.00       General fund balance       29,984,352       0       0       0       0         51.00       Donor created - endowment fund balance - unrestricted       0       0	37.00		2, 212, 967	0	0	0	37.00
40.00       Notes and Loans payable (short term)       0       0       0         41.00       Deferred income       0       0       0         42.00       Accelerated payments       0       0       0         42.00       Accelerated payments       0       0       0         43.00       Due to other funds       0       0       0         43.00       Other current liabilities       6,965,238       0       0         45.00       Total current liabilities (sum of lines 37 thru 44)       12,135,141       0       0         1000       TERM LIABILITIES       0       0       0       0         46.00       Mortgage payable       3,952,558       0       0       0         47.00       Notes payable       3,952,558       0       0       0         48.00       Unsecured Loans       0       0       0       0         50.00       Total long term liabilities (sum of lines 46 thru 49)       3,952,558       0       0       0         51.00       General fund balance       29,984,352       0       0       0         52.00       General fund balance       endowment fund balance - unrestricted       0       0       0	38.00		2, 956, 936		0	0	
41.00Deferred income00042.00Accelerated payments00043.00Due to other funds0000Other current liabilities6,965,238000Total current liabilities (sum of lines 37 thru 44)12,135,1410012.00GTERM LIABILITIESVertication of the system46.00Mortgage payable00010.00Other long term liabilities000048.00Unsecured loans00000Other long term liabilities (sum of lines 46 thru 49)3,952,5580000Total long term liabilities (sum of lines 46 thru 49)3,952,5580000Total long term liabilities (sum of lines 46 thru 49)16,087,6990000CAPI TAL ACCOUNTS000000Donor created - endowment fund balance - restricted000051.00Donor created - endowment fund balance000055.00Plant fund balance - invested in plant000058.00Plant fund balance - invested in plant000058.00Plant fund balance - reserve for plant improvement, replacement, and expansion000			0	0	0	0	
42.00       Accelerated payments       0       0       0         43.00       Due to other funds       0       0       0       0         43.00       Other current liabilities       6,965,238       0       0       0         45.00       Total current liabilities (sum of lines 37 thru 44)       12,135,141       0       0       0         45.00       Mortgage payable       0       0       0       0       0         46.00       Mortgage payable       3,952,558       0       0       0       0         47.00       Notes payable       3,952,558       0       0       0       0       0         48.00       Unsecured loans       0<			0	0	0	0	40.00
43.00Due to other funds00044.00Other current liabilities6,965,2380045.00Total current liabilities (sum of lines 37 thru 44)12,135,14100LONG TERM LIABILITIES46.00Mortgage payable00047.00Notes payable000048.00Unsecured loans000049.00Other long term liabilities000049.00Other long term liabilities000050.00Total liabilities (sum of lines 46 thru 49)3,952,55800051.00Total liabilities (sum of lines 45 and 50)16,087,69900060000000061.00Donor created - endowment fund balance - restricted000052.00Governing body created - endowment fund balance29,984,35200055.00Donor created - endowment fund balance - unrestricted000055.00Plant fund balance - invested in plant0000058.00Plant fund balance - reserve for plant improvement, replacement, and expansion0000			0	0	0	0	41.00
44.00Other current liabilities6,965,2380045.00Total current liabilities (sum of lines 37 thru 44)12,135,14100LONG TERM LIABILITIES46.00Mortgage payable0007.00Notes payable3,952,558000Unsecured loans000048.00Unsecured loans00000Other long term liabilities000049.00Other long term liabilities (sum of lines 46 thru 49)3,952,55800051.00Total long term liabilities (sum of lines 45 and 50)16,087,6990006eneral fund balance29,984,352000052.00Generat fund balance - restricted000053.00Specific purpose fund000054.00Donor created - endowment fund balance - unrestricted00055.00Plant fund balance - invested in plant00058.00Plant fund balance - reserve for plant improvement, replacement, and expansion000			0	0	0	0	
LONG TERM LIABILITIES46.00Mortgage payable47.00Notes payable47.00Notes payable48.00Unsecured loans49.00Other long term liabilities49.00Other long term liabilities50.00Total long term liabilities (sum of lines 46 thru 49)51.00Total liabilities (sum of lines 45 and 50)51.00Total long term liabilities52.00General fund balance52.00General fund balance53.00Specific purpose fund54.00Donor created - endowment fund balance - unrestricted55.00Governing body created - endowment fund balance57.00Plant fund balance - invested in plant58.00Plant fund balance - reserve for plant improvement, replacement, and expansion	44.00		6, 965, 238	0	0	0	44.00
46.00Mortgage payable00047.00Notes payable3, 952, 5580048.00Unsecured Loans00049.00Other Long term Liabilities00050.00Total Long term Liabilities (sum of Lines 46 thru 49)3, 952, 5580051.00Total Liabilities (sum of Lines 45 and 50)16, 087, 699006CAPITAL ACCOUNTS52.00General fund balance29, 984, 352053.00Specific purpose fund0054.00Donor created - endowment fund balance - restricted055.00Governing body created - endowment fund balance057.00Plant fund balance - invested in plant058.00Plant fund balance - reserve for plant improvement, replacement, and expansion0	45.00		12, 135, 141	0	0	0	45.00
47.00Notes payable3,952,5580048.00Unsecured Loans00049.00Other Long term Liabilities00050.00Total Long term Liabilities (sum of Lines 46 thru 49)3,952,5580051.00Total Liabilities (sum of Lines 45 and 50)16,087,6990052.00General fund balance29,984,352053.00Specific purpose fund0054.00Donor created - endowment fund balance - restricted055.00Governing body created - endowment fund balance057.00Plant fund balance - invested in plant058.00Plant fund balance - reserve for plant improvement, replacement, and expansion0						0	1 1/ 0/
48.00       Unsecured Loans       0       0       0         49.00       Other Long term Liabilities       0       0       0       0         50.00       Total Liabilities (sum of Lines 46 thru 49)       3,952,558       0       0       0       0         51.00       Total Liabilities (sum of Lines 45 and 50)       16,087,699       0       0       0         6eneral fund balance       29,984,352       0       0       0       0         52.00       General fund balance       29,984,352       0       0       0       0         53.00       Specific purpose fund       0			2 052 559			0	
49.00Other long term liabilities00050.00Total long term liabilities (sum of lines 46 thru 49)3,952,55800051.00Total liabilities (sum of lines 45 and 50)16,087,699000CAPITAL ACCOUNTS52.00General fund balance29,984,3520053.00Specific purpose fund00054.00Donor created - endowment fund balance - restricted0055.00Donor created - endowment fund balance - unrestricted0056.00Governing body created - endowment fund balance0057.00Plant fund balance - invested in plant0058.00Plant fund balance - reserve for plant improvement, replacement, and expansion00			3, 70∠, 008 ∩		0	0	
51.00       Total liabilities (sum of lines 45 and 50)       16,087,699       0       0         CAPITAL ACCOUNTS         52.00       General fund balance       29,984,352       0         53.00       Specific purpose fund       0       0         54.00       Donor created - endowment fund balance - restricted       0       0         55.00       Donor created - endowment fund balance - unrestricted       0       0         56.00       Governing body created - endowment fund balance       0       0         57.00       Plant fund balance - invested in plant       0       0         58.00       Plant fund balance - reserve for plant improvement, replacement, and expansion       0       0			0	-	0	0	49.00
CAPI TAL ACCOUNTS         52.00       General fund balance         53.00       Specific purpose fund         54.00       Donor created - endowment fund balance - restricted         55.00       Donor created - endowment fund balance - unrestricted         56.00       Governing body created - endowment fund balance         57.00       Plant fund balance - invested in plant         58.00       Plant fund balance - reserve for plant improvement, replacement, and expansion	50.00	Total long term liabilities (sum of lines 46 thru 49)	3, 952, 558	0	0	0	50.0
52.00       General fund balance       29,984,352         53.00       Specific purpose fund       0         54.00       Donor created - endowment fund balance - restricted       0         55.00       Donor created - endowment fund balance - unrestricted       0         56.00       Governing body created - endowment fund balance       0         57.00       Plant fund balance - invested in plant       0         58.00       Plant fund balance - reserve for plant improvement, replacement, and expansion       0	51.00		16, 087, 699	0	0	0	51.0
53.00       Specific purpose fund       0         54.00       Donor created - endowment fund balance - restricted       0         55.00       Donor created - endowment fund balance - unrestricted       0         56.00       Governing body created - endowment fund balance       0         57.00       Plant fund balance - invested in plant       0         58.00       Plant fund balance - reserve for plant improvement, replacement, and expansion       0	E2 00		20,004,252				- 
54.00       Donor created - endowment fund balance - restricted       0         55.00       Donor created - endowment fund balance - unrestricted       0         56.00       Governing body created - endowment fund balance       0         57.00       Plant fund balance - invested in plant       0         58.00       Plant fund balance - reserve for plant improvement, replacement, and expansion       0			27, 784, 352				52.0 53.0
55.00       Donor created - endowment fund balance - unrestricted       0         56.00       Governing body created - endowment fund balance       0         57.00       Plant fund balance - invested in plant       0         58.00       Plant fund balance - reserve for plant improvement, replacement, and expansion       0					0		54.0
57.00       Plant fund balance - invested in plant         58.00       Plant fund balance - reserve for plant improvement,         replacement, and expansion					Ő		55.0
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion		0			0		56.0
replacement, and expansion						0	
	58.00					0	58.0
	59 00		29 984 352	0	0	0	59.00
		, , , , , , , , , , , , , , , , , , , ,			0	0	

Heal th	Financial Systems	HARRI SON COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1331	Period: From 01/01/2021 To 12/31/2021	Worksheet G-7 Date/Time Pre 5/31/2022 11:	epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)		31, 870, 590 -1, 886, 238 29, 984, 352 0 29, 984, 352 0 29, 984, 352 0				$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	Endowment Fund	29, 984, 352 Pl ant	Fund	0		19.00
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	000	0 0 0 0 0 0 0		0 0		9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	U			0		19.00

Heal th	Financial Systems HARRISON COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet G-2 Parts I & II Date/Time Pre 5/31/2022 11:	pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
1.00	General Inpatient Routine Services Hospital		6, 880, 3	16	6, 880, 315	1.00
2.00	SUBPROVIDER - IPF		0, 880, 3	15	0, 880, 315	2.00
2.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE		1			9.00
10.00	Total general inpatient care services (sum of lines 1-9)		6, 880, 3	15	6, 880, 315	10.00
	Intensive Care Type Inpatient Hospital Services		-			
11.00	INTENSIVE CARE UNIT		1, 570, 9	38	1, 570, 988	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)		1 570 0	20	4 570 000	15.00
16.00	Total intensive care type inpatient hospital services (sum of	Tines	1, 570, 9	38	1, 570, 988	16.00
17.00	11-15) Total inpatient routine care services (sum of lines 10 and 16		8, 451, 3	2	8, 451, 303	17.00
18.00	Ancillary services	)	17, 700, 1		166, 813, 845	18.00
19.00	Outpatient services		17,700,1	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 SERVI CES			0 11, 037, 056	11, 037, 056	23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	3 to Wkst.	26, 151, 4	19 160, 161, 585	186, 313, 004	28.00
	G-3, line 1)					
20.00	PART II - OPERATING EXPENSES		1	(1.0(7.510		20.00
29.00 30.00	Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY)			61, 066, 518 0		29.00 30.00
30.00	ADD (SPECIFT)			0		30.00
31.00				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			1	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 4	2)(transfer		61, 066, 518		43.00
	to Wkst. G-3, line 4)		I	T	I	I

Heal th	Financial Systems	HARRI SON COUNTY	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES		Provider CCN: 15-1331	Peri od:	Worksheet G-3	
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/31/2022 11:	pared:
					3/31/2022 11.	29 dili
				-	1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	L. column 3. lin	e 28)		186, 313, 004	1.00
2.00	Less contractual allowances and discounts on				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 miscellane	ous communication	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
	Revenue from Laundry and Linen service				0	13.00
	Revenue from meals sold to employees and gue	sts			124, 341	
	Revenue from rental of living quarters				0	
	Revenue from sale of medical and surgical su		han patients		0	16.00
	Revenue from sale of drugs to other than pat				0	17.00
	Revenue from sale of medical records and abs				13, 271	
	Tuition (fees, sale of textbooks, uniforms,	,			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a	nd canteen			0	20.00
	Rental of vending machines				0	21.00
22.00	Rental of hospital space				219, 637	
23.00	Governmental appropriations OTHER OPERATING INCOME				30, 261 1, 583, 786	
24.00 24.01	MOB				935, 562	
	MISC INCOME				935, 562 678, 199	
	IGT				965, 367	
	MISC INCOME				24, 800	
	COVID-19 PHE Funding				1, 259, 053	
	Total other income (sum of lines 6-24)				5, 858, 167	
	Total (line 5 plus line 25)				-1, 886, 238	
	OTHER EXPENSES (SPECIFY)				-1, 000, 230	20.00
	Total other expenses (sum of line 27 and sub	scrints)			0	28.00
	Net income (or loss) for the period (line 26				-1, 886, 238	
27.00				I	., 333, 200	_// 00