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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/26/2023 5:21 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2023 Time: 5:21 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARRISON COUNTY HOSPITAL (15-1331) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	517,372	-174,619	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	9,921	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	527,293	-174,619	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 5:21 pm

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

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

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2022	12/31/2022	20.00
21.00	Type of Control (see instructions)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 5:21 pm

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 5:21 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 5:21 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	N	68.00

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

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

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		0	88.00

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 5:21 pm

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	Y	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 5:21 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	492,974	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.01	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 5:21 pm

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

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

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2023 5:21 pm

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/04/2023	Y	05/04/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 5:21 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CLINT	BRILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND COMPANY		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502.992.3512	CBRILL@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 5:21 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2023 5:21 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	72,216.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	72,216.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	7,728.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	79,944.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2023 5:21 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
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)	854	84	3,009			1.00
2.00	HMO and other (see instructions)	793	897				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	57	0	57			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	911	84	3,066			7.00
8.00	INTENSIVE CARE UNIT	84	0	322			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		20	698			13.00
14.00	Total (see instructions)	995	104	4,086	0.00	493.07	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	493.07	27.00
28.00	Observation Bed Days		23	905			28.00
29.00	Ambulance Trips	1,545					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2023 5:21 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	251	22	960	1.00
2.00	HMO and other (see instructions)			170	216		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	251	22	960	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/26/2023 5:21 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.274577	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,428,849	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	45,952,402	6.00
7.00	Medicaid cost (line 1 times line 6)	12,617,473	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	4,188,624	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,188,624	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	481,600	1,208,917	1,690,517	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	132,236	1,208,917	1,341,153	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	132,236	1,208,917	1,341,153	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,627,366	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	547,542	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	842,373	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,784,993	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,883,257	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,224,410	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,413,034	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,583,169	1,583,169	162,720	1,745,889	1.00
1.01	00101	MOB		628,857	628,857	0	628,857	1.01
1.02	00102	AMB DEPR		0	0	57,611	57,611	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,016,239	1,016,239	3,970	1,020,209	2.00
2.01	00201	AMB EQUIP		0	0	325,544	325,544	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	231,236	953,132	1,184,368	184,068	1,368,436	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	1,912,233	5,854,383	7,766,616	-2,676	7,763,940	5.01
5.02	00570	ADMITTING	593,700	162,221	755,921	-263	755,658	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	404,327	811,467	1,215,794	0	1,215,794	5.03
7.00	00700	OPERATION OF PLANT	322,562	1,497,438	1,820,000	0	1,820,000	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37,219	237,717	274,936	0	274,936	8.00
9.00	00900	HOUSEKEEPING	516,595	320,005	836,600	0	836,600	9.00
10.00	01000	DIETARY	511,124	526,173	1,037,297	-579,641	457,656	10.00
11.00	01100	CAFETERIA	0	0	0	579,641	579,641	11.00
13.00	01300	NURSING ADMINISTRATION	774,236	257,056	1,031,292	0	1,031,292	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	226,947	2,464,557	2,691,504	-1,861,792	829,712	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	621,022	280,593	901,615	0	901,615	16.00
17.00	01700	SOCIAL SERVICE	383,415	86,820	470,235	0	470,235	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,491,116	1,829,960	6,321,076	-220,127	6,100,949	30.00
31.00	03100	INTENSIVE CARE UNIT	525,732	158,790	684,522	-3,555	680,967	31.00
43.00	04300	NURSERY	0	114	114	156,987	157,101	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,064,629	719,095	1,783,724	-123,262	1,660,462	50.00
53.00	05300	ANESTHESIOLOGY	0	1,223,186	1,223,186	-16,427	1,206,759	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,146,239	1,095,830	2,242,069	-98,396	2,143,673	54.00
60.00	06000	LABORATORY	989,755	2,120,284	3,110,039	-172,126	2,937,913	60.00
65.00	06500	RESPIRATORY THERAPY	0	629,196	629,196	-52,997	576,199	65.00
66.00	06600	PHYSICAL THERAPY	390,488	77,293	467,781	-52,369	415,412	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	42,847	42,847	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	9,495	9,495	68.00
69.00	06900	ELECTROCARDIOLOGY	484,034	169,575	653,609	26,003	679,612	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	325	325	2,000,335	2,000,660	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,017,388	1,017,388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	356,118	2,112,207	2,468,325	-941	2,467,384	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	33,810	18,331	52,141	-13,930	38,211	90.00
90.01	09001	SENIOR CARE	88,600	144,994	233,594	-33	233,561	90.01
90.02	09002	GENERAL SURGERY	856,228	321,734	1,177,962	-956	1,177,006	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	633,774	317,001	950,775	-12,156	938,619	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	571,025	263,754	834,779	-17,922	816,857	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	1,218,667	462,845	1,681,512	-139,823	1,541,689	90.05
90.06	09006	OBGYN - DR SAUER	506,123	253,565	759,688	-4,768	754,920	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1,226,936	569,989	1,796,925	-36,183	1,760,742	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	424,592	237,012	661,604	-40,166	621,438	90.08
90.09	09009	PAIN MANAGEMENT	156,885	28,457	185,342	-5,160	180,182	90.09
90.10	09010	DERMATOLOGY	484,549	140,651	625,200	-4,717	620,483	90.10
90.11	09011	KIDS FIRST	1,269,556	1,031,360	2,300,916	-340,788	1,960,128	90.11
91.00	09100	EMERGENCY	2,281,914	821,278	3,103,192	-17,148	3,086,044	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,334,456	1,693,410	4,027,866	-581,487	3,446,379	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		137,850	137,850	-137,850	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,069,842	33,257,913	61,327,755	28,950	61,356,705	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,698,831	977,783	2,676,614	-28,840	2,647,774	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	388,371	214,063	602,434	-110	602,324	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	30,157,044	34,449,759	64,606,803	0	64,606,803	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-13,734	1,732,155	1.00
1.01	00101	MOB	0	628,857	1.01
1.02	00102	AMB DEPR	0	57,611	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	1,020,209	2.00
2.01	00201	AMB EQUIP	0	325,544	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,368,436	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	-1,569,113	6,194,827	5.01
5.02	00570	ADMITTING	0	755,658	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,215,794	5.03
7.00	00700	OPERATION OF PLANT	0	1,820,000	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	274,936	8.00
9.00	00900	HOUSEKEEPING	0	836,600	9.00
10.00	01000	DIETARY	0	457,656	10.00
11.00	01100	CAFETERIA	-123,025	456,616	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,031,292	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	829,712	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-23,046	878,569	16.00
17.00	01700	SOCIAL SERVICE	0	470,235	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-973,001	5,127,948	30.00
31.00	03100	INTENSIVE CARE UNIT	0	680,967	31.00
43.00	04300	NURSERY	0	157,101	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	1,660,462	50.00
53.00	05300	ANESTHESIOLOGY	-1,190,620	16,139	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,143,673	54.00
60.00	06000	LABORATORY	-2,547	2,935,366	60.00
65.00	06500	RESPIRATORY THERAPY	0	576,199	65.00
66.00	06600	PHYSICAL THERAPY	0	415,412	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	42,847	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,495	68.00
69.00	06900	ELECTROCARDIOLOGY	0	679,612	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,000,660	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,017,388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,467,384	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	38,211	90.00
90.01	09001	SENIOR CARE	-24,906	208,655	90.01
90.02	09002	GENERAL SURGERY	-811,791	365,215	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	-333,165	605,454	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	-422,321	394,536	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	-1,080,876	460,813	90.05
90.06	09006	OBGYN - DR SAUER	-555,433	199,487	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	-339,824	1,420,918	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	-265,702	355,736	90.08
90.09	09009	PAIN MANAGEMENT	-207,265	-27,083	90.09
90.10	09010	DERMATOLOGY	-433,803	186,680	90.10
90.11	09011	KIDS FIRST	-849,639	1,110,489	90.11
91.00	09100	EMERGENCY	0	3,086,044	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-16,463	3,429,916	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,236,274	52,120,431	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,647,774	192.00
194.00	07950	MARKETING	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	602,324	194.01
194.02	07952	MOB	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,236,274	55,370,529	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,017,723	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	0		0	3,017,723	
	B - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,017,388	1.00
	0		0	1,017,388	
	C - AMBULANCE CAPITAL				
1.00	AMB DEPR	1.02	0	57,611	1.00
2.00	AMB EQUIP	2.01	0	325,544	2.00
	0		0	383,155	
	D - INTEREST				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	137,850	1.00
	0		0	137,850	
	E - EKG				
1.00	ELECTROCARDIOLOGY	69.00	13,016	21,947	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		13,016	21,947	
	F - NURSERY				
1.00	NURSERY	43.00	156,987	0	1.00
	0		156,987	0	
	G - THERAPY				
1.00	SPEECH PATHOLOGY	68.00	7,927	1,568	1.00
2.00	OCCUPATIONAL THERAPY	67.00	35,769	7,078	2.00
	0		43,696	8,646	
	H - CAFETERIA				
1.00	CAFETERIA	11.00	285,616	294,025	1.00
	0		285,616	294,025	
	I - DEPRECIATION RECLASS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	24,870	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,970	2.00
	0		0	28,840	
	J - AMBULANCE WORKERS COMP				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	151,033	1.00
	0		0	151,033	
	K - MISCELLANEOUS BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33,035	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	0		0	33,035	

RECLASSIFICATIONS	Provider CCN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet A-6 Date/Time Prepared: 5/26/2023 5:21 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
500.00	Grand Total: Increases		499,315	5,093,642	500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,861,792	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	37,991	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	3,555	0		3.00
4.00	OPERATING ROOM	50.00	0	123,262	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	16,427	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	98,396	0		6.00
7.00	LABORATORY	60.00	0	155,171	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	31,050	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	27	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	8,960	0		10.00
11.00	DRUGS CHARGED TO PATIENTS	73.00	0	941	0		11.00
12.00	CLINIC	90.00	0	13,930	0		12.00
13.00	SENIOR CARE	90.01	0	33	0		13.00
14.00	GENERAL SURGERY	90.02	0	956	0		14.00
15.00	HARRISON CRAWFORD HEALTHCARE	90.03	0	12,156	0		15.00
16.00	CORYDON MEDICAL ASSOCIATES	90.04	0	17,922	0		16.00
17.00	ORTHOPEDIC SURGERY - DR KLINE	90.05	0	139,823	0		17.00
18.00	OBGYN - DR SAUER	90.06	0	4,768	0		18.00
19.00	FIRST CAPITAL MEDICAL GROUP	90.07	0	36,183	0		19.00
20.00	SOUTH HARRISON FAMILY MEDICINE	90.08	0	40,166	0		20.00
21.00	PAIN MANAGEMENT	90.09	0	5,160	0		21.00
22.00	DERMATOLOGY	90.10	0	4,717	0		22.00
23.00	KIDS FIRST	90.11	0	340,788	0		23.00
24.00	EMERGENCY	91.00	0	16,446	0		24.00
25.00	AMBULANCE SERVICES	95.00	0	47,103	0		25.00
	0		0	3,017,723			
	B - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,017,388	0		1.00
	0		0	1,017,388			
	C - AMBULANCE CAPITAL						
1.00	AMBULANCE SERVICES	95.00	0	383,155	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	383,155			
	D - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	137,850	11		1.00
	0		0	137,850			
	E - EKG						
1.00	LABORATORY	60.00	12,261		0		1.00
2.00	RESPIRATORY THERAPY	65.00		21,947	0		2.00
3.00	EMERGENCY	91.00	662		0		3.00
4.00	AMBULANCE SERVICES	95.00	93		0		4.00
	0		13,016	21,947			
	F - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	156,987	0	0		1.00
	0		156,987	0			
	G - THERAPY						
1.00	PHYSICAL THERAPY	66.00	43,696	8,646	0		1.00
2.00		0.00	0	0	0		2.00
	0		43,696	8,646			
	H - CAFETERIA						
1.00	DIETARY	10.00	285,616	294,025	0		1.00
	0		285,616	294,025			
	I - DEPRECIATION RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	28,840	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	28,840			
	J - AMBULANCE WORKERS COMP						
1.00	AMBULANCE SERVICES	95.00	0	151,033	0		1.00
	0		0	151,033			
	K - MISCELLANEOUS BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.01	0	2,676	0		1.00
2.00	ADMITTING	5.02	0	263	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	25,149	0		3.00
4.00	LABORATORY	60.00	0	4,694	0		4.00
5.00	EMERGENCY	91.00	0	40	0		5.00
6.00	AMBULANCE SERVICES	95.00	0	103	0		6.00
7.00	PHYSICIAN BILLING	194.01	0	110	0		7.00
	0		0	33,035			
500.00	Grand Total: Decreases		499,315	5,093,642			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2023 5:21 pm

		Beginning Balances	Acquisitions Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,001,138	0	0	0	0	1.00
2.00	Land Improvements	3,355,876	0	0	0	45,414	2.00
3.00	Buildings and Fixtures	37,464,364	4,957,483	0	4,957,483	0	3.00
4.00	Building Improvements	857,272	3,386,598	0	3,386,598	0	4.00
5.00	Fixed Equipment	346,074	0	0	0	0	5.00
6.00	Movable Equipment	28,128,109	0	0	0	2,888,137	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	73,152,833	8,344,081	0	8,344,081	2,933,551	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	73,152,833	8,344,081	0	8,344,081	2,933,551	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,001,138	0	1.00
2.00	Land Improvements	3,310,462	0	2.00
3.00	Buildings and Fixtures	42,421,847	0	3.00
4.00	Building Improvements	4,243,870	0	4.00
5.00	Fixed Equipment	346,074	0	5.00
6.00	Movable Equipment	25,239,972	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	78,563,363	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	78,563,363	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/26/2023 5:21 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,475,646	0	0	107,523	0	1.00
1.01	MOB	302,681	77,663	61,572	0	0	1.01
1.02	AMB DEPR	0	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,016,239	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)	2,794,566	77,663	61,572	107,523	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,583,169	1.00
1.01	MOB	186,941	628,857	1.01
1.02	AMB DEPR	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,016,239	2.00
2.01	AMB EQUIP	0	0	2.01
3.00	Total (sum of lines 1-2)	186,941	3,228,265	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2023 5:21 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	53,323,391	0	53,323,391	0.678731	0	1.00
1.01	MOB	0	0	0	0.000000	0	1.01
1.02	AMB DEPR	0	0	0	0.000000	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	25,239,972	0	25,239,972	0.321269	0	2.00
2.01	AMB EQUIP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	78,563,363	0	78,563,363	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,500,516	0	1.00
1.01	MOB	0	0	0	302,681	77,663	1.01
1.02	AMB DEPR	0	0	0	57,611	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,020,209	0	2.00
2.01	AMB EQUIP	0	0	0	325,544	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	3,206,561	77,663	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	124,116	107,523	0	0	1,732,155	1.00
1.01	MOB	61,572	0	0	186,941	628,857	1.01
1.02	AMB DEPR	0	0	0	0	57,611	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,020,209	2.00
2.01	AMB EQUIP	0	0	0	0	325,544	2.01
3.00	Total (sum of lines 1-2)	185,688	107,523	0	186,941	3,764,376	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 5:21 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - MOB (chapter 2)		0	MOB	1.01	0	1.01
1.02	Investment income - AMB DEPR (chapter 2)		0	AMB DEPR	1.02	0	1.02
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - AMB EQUIP (chapter 2)		0	AMB EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,173	ADMINISTRATIVE & GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,654,857			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-123,025	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-23,046	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - MOB		0	MOB	1.01	0	26.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 5:21 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
26.02	Depreciation - AMB DEPR		0	AMB DEPR	1.02	0	26.02
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - AMB EQUIP		0	AMB EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME - A&G	B	-62,945	ADMINISTRATIVE & GENERAL	5.01	0	33.00
33.01	MISC INCOME - LABORATORY	B	-450	LABORATORY	60.00	0	33.01
33.02	INTEREST	B	-5,073	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.02
33.03	PROVIDER TAX FEE	A	-1,307,198	ADMINISTRATIVE & GENERAL	5.01	0	33.03
33.04	UNNECESSARY BORROWING	A	-8,661	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.04
33.05	CRNA	A	-1,190,620	ANESTHESIOLOGY	53.00	0	33.05
33.06	LOBBYING FEES	A	-7,185	ADMINISTRATIVE & GENERAL	5.01	0	33.06
33.07	MARKETING EXPENSE	A	-188,612	ADMINISTRATIVE & GENERAL	5.01	0	33.07
33.08	CLINIC RENT - SENIOR CARE	B	-24,906	SENIOR CARE	90.01	0	33.08
33.09	CLINIC RENT - GENERAL SURGERY	B	-16,560	GENERAL SURGERY	90.02	0	33.09
33.10	CLINIC RENT - HARRISON CRAWFORD HEAL	B	-74,957	HARRISON CRAWFORD HEALTHCARE	90.03	0	33.10
33.11	CLINIC RENT - CORYDON MEDICAL ASSOCI	B	-95,766	CORYDON MEDICAL ASSOCIATES	90.04	0	33.11
33.12	CLINIC RENT - ORTHOPEDIC SURGERY - D	B	-114,680	ORTHOPEDIC SURGERY - DR KLINE	90.05	0	33.12
33.13	CLINIC RENT - OBGYN - DR SAUER	B	-34,406	OBGYN - DR SAUER	90.06	0	33.13
33.14	CLINIC RENT - FIRST CAPITAL MEDICAL	B	-120,083	FIRST CAPITAL MEDICAL GROUP	90.07	0	33.14
33.15	CLINIC RENT - SOUTH HARRISON FAMILY	B	-53,298	SOUTH HARRISON FAMILY MEDICINE	90.08	0	33.15
33.16	CLINIC RENT - PAIN MANAGEMENT	B	-26,148	PAIN MANAGEMENT	90.09	0	33.16
33.17	CLINIC RENT - DERMATOLOGY	B	-28,719	DERMATOLOGY	90.10	0	33.17
33.18	CLINIC RENT - KIDS FIRST	B	-71,906	KIDS FIRST	90.11	0	33.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,236,274				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2023 5:21 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	17.00	SOCIAL SERVICE	153,952	0	153,952	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	973,001	973,001	0	0	0	2.00
3.00	60.00	LABORATORY	20,970	2,097	18,873	0	0	3.00
4.00	90.02	GENERAL SURGERY	795,231	795,231	0	0	0	4.00
5.00	90.03	HARRISON CRAWFORD HEALTHCARE	258,208	258,208	0	0	0	5.00
6.00	90.04	CORYDON MEDICAL ASSOCIATES	326,555	326,555	0	0	0	6.00
7.00	90.05	ORTHOPEDIC SURGERY - DR KLINE	966,196	966,196	0	0	0	7.00
8.00	90.06	OBGYN - DR SAUER	521,027	521,027	0	0	0	8.00
9.00	90.07	FIRST CAPITAL MEDICAL GROUP	219,741	219,741	0	0	0	9.00
10.00	90.08	SOUTH HARRISON FAMILY MEDICINE	212,404	212,404	0	0	0	10.00
11.00	90.09	PAIN MANAGEMENT	181,117	181,117	0	0	0	11.00
12.00	90.10	DERMATOLOGY	405,084	405,084	0	0	0	12.00
13.00	90.11	KIDS FIRST	777,733	777,733	0	0	0	13.00
14.00	91.00	EMERGENCY	170,943	0	170,943	0	0	14.00
15.00	95.00	AMBULANCE SERVICES	16,463	16,463	0	0	0	15.00
200.00			5,998,625	5,654,857	343,768		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	17.00	SOCIAL SERVICE	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	90.02	GENERAL SURGERY	0	0	0	0	0	4.00
5.00	90.03	HARRISON CRAWFORD HEALTHCARE	0	0	0	0	0	5.00
6.00	90.04	CORYDON MEDICAL ASSOCIATES	0	0	0	0	0	6.00
7.00	90.05	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	0	0	7.00
8.00	90.06	OBGYN - DR SAUER	0	0	0	0	0	8.00
9.00	90.07	FIRST CAPITAL MEDICAL GROUP	0	0	0	0	0	9.00
10.00	90.08	SOUTH HARRISON FAMILY MEDICINE	0	0	0	0	0	10.00
11.00	90.09	PAIN MANAGEMENT	0	0	0	0	0	11.00
12.00	90.10	DERMATOLOGY	0	0	0	0	0	12.00
13.00	90.11	KIDS FIRST	0	0	0	0	0	13.00
14.00	91.00	EMERGENCY	0	0	0	0	0	14.00
15.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	15.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	17.00	SOCIAL SERVICE	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	973,001		2.00
3.00	60.00	LABORATORY	0	0	0	2,097		3.00
4.00	90.02	GENERAL SURGERY	0	0	0	795,231		4.00
5.00	90.03	HARRISON CRAWFORD HEALTHCARE	0	0	0	258,208		5.00
6.00	90.04	CORYDON MEDICAL ASSOCIATES	0	0	0	326,555		6.00
7.00	90.05	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	966,196		7.00
8.00	90.06	OBGYN - DR SAUER	0	0	0	521,027		8.00
9.00	90.07	FIRST CAPITAL MEDICAL GROUP	0	0	0	219,741		9.00
10.00	90.08	SOUTH HARRISON FAMILY MEDICINE	0	0	0	212,404		10.00
11.00	90.09	PAIN MANAGEMENT	0	0	0	181,117		11.00
12.00	90.10	DERMATOLOGY	0	0	0	405,084		12.00
13.00	90.11	KIDS FIRST	0	0	0	777,733		13.00
14.00	91.00	EMERGENCY	0	0	0	0		14.00
15.00	95.00	AMBULANCE SERVICES	0	0	0	16,463		15.00
200.00			0	0	0	5,654,857		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/26/2023 5:21 pm

Respiratory Therapy | Cost

Line	Description					1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	8,760.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.66	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.83	34.83	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/26/2023 5:21 pm

Respiratory Therapy | Cost

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

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

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	610,222	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	610,222	63.00
64.00	Total cost of outside supplier services (from your records)	558,473	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,732,155	1,732,155				1.00
1.01	00101	MOB	628,857	0	628,857			1.01
1.02	00102	AMB DEPR	57,611	0	0	57,611		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,020,209				1,020,209	2.00
2.01	00201	AMB EQUIP	325,544				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,368,436	2,770	0	0	1,632	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	6,194,827	278,569	3,597	0	164,072	5.01
5.02	00570	ADMITTING	755,658	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,215,794	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	1,820,000	151,273	0	0	89,097	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	274,936	12,688	0	0	7,473	8.00
9.00	00900	HOUSEKEEPING	836,600	27,177	0	0	16,007	9.00
10.00	01000	DIETARY	457,656	79,079	0	0	46,576	10.00
11.00	01100	CAFETERIA	456,616	39,505	0	0	23,268	11.00
13.00	01300	NURSING ADMINISTRATION	1,031,292	6,649	0	0	3,916	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	829,712	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	878,569	44,117	0	0	25,984	16.00
17.00	01700	SOCIAL SERVICE	470,235	2,660	0	0	1,566	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,127,948	300,357	0	0	176,906	30.00
31.00	03100	INTENSIVE CARE UNIT	680,967	40,128	0	0	23,635	31.00
43.00	04300	NURSERY	157,101	8,311	0	0	4,895	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,660,462	245,478	0	0	144,582	50.00
53.00	05300	ANESTHESIOLOGY	16,139	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,143,673	128,612	0	0	75,750	54.00
60.00	06000	LABORATORY	2,935,366	67,596	0	0	39,813	60.00
65.00	06500	RESPIRATORY THERAPY	576,199	14,710	0	0	8,664	65.00
66.00	06600	PHYSICAL THERAPY	415,412	49,769	0	0	29,313	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,847	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,495	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	679,612	25,265	0	0	14,881	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,000,660	60,338	0	0	35,538	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,017,388	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,467,384	16,982	0	0	10,002	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	38,211	10,527	0	0	6,200	90.00
90.01	09001	SENIOR CARE	208,655	0	20,974	0	0	90.01
90.02	09002	GENERAL SURGERY	365,215	0	13,946	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	605,454	0	63,124	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	394,536	0	80,649	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	460,813	0	96,576	0	0	90.05
90.06	09006	OBGYN - DR SAUER	199,487	0	28,975	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1,420,918	0	101,128	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	355,736	0	44,884	0	0	90.08
90.09	09009	PAIN MANAGEMENT	-27,083	0	22,020	0	0	90.09
90.10	09010	DERMATOLOGY	186,680	0	24,185	0	0	90.10
90.11	09011	KIDS FIRST	1,110,489	0	60,555	0	0	90.11
91.00	09100	EMERGENCY	3,086,044	101,380	0	0	59,711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,429,916	0	0	57,611	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,120,431	1,713,940	560,613	57,611	1,009,481	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,289	0	0	6,649	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,647,774	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	602,324	6,926	0	0	4,079	194.01
194.02	07952	MOB	0	0	68,244	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	55,370,529	1,732,155	628,857	57,611	1,020,209	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	ADMITTING	
			2.01	4.00	4A	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP	325,544					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,372,838				4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	87,724	6,728,789	6,728,789		5.01
5.02	00570	ADMITTING	0	27,236	782,894	108,301	891,195	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	18,549	1,234,343	170,752	0	5.03
7.00	00700	OPERATION OF PLANT	0	14,798	2,075,168	287,066	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,707	296,804	41,058	0	8.00
9.00	00900	HOUSEKEEPING	0	23,699	903,483	124,982	0	9.00
10.00	01000	DIETARY	0	10,345	593,656	82,123	0	10.00
11.00	01100	CAFETERIA	0	13,103	532,492	73,662	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	35,518	1,077,375	149,038	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,411	840,123	116,218	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,489	977,159	135,174	0	16.00
17.00	01700	SOCIAL SERVICE	0	17,589	492,050	68,067	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	198,818	5,804,029	802,878	43,938	30.00
31.00	03100	INTENSIVE CARE UNIT	0	24,118	768,848	106,358	4,304	31.00
43.00	04300	NURSERY	0	7,202	177,509	24,556	6,969	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	48,840	2,099,362	290,413	68,281	50.00
53.00	05300	ANESTHESIOLOGY	0	0	16,139	2,233	12,443	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,584	2,400,619	332,087	193,690	54.00
60.00	06000	LABORATORY	0	44,843	3,087,618	427,123	135,326	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	599,573	82,941	14,377	65.00
66.00	06600	PHYSICAL THERAPY	0	15,909	510,403	70,606	16,301	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,641	44,488	6,154	1,722	67.00
68.00	06800	SPEECH PATHOLOGY	0	364	9,859	1,364	922	68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,802	742,560	102,721	54,793	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,096,536	290,022	21,115	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,017,388	140,739	15,275	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,337	2,510,705	347,316	41,387	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,551	56,489	7,814	729	90.00
90.01	09001	SENIOR CARE	0	4,065	233,694	32,328	1,744	90.01
90.02	09002	GENERAL SURGERY	0	39,279	418,440	57,884	987	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	29,074	697,652	96,509	4,552	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	26,196	501,381	69,358	4,233	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	55,906	613,295	84,840	4,895	90.05
90.06	09006	OBGYN - DR SAUER	0	23,218	251,680	34,816	1,465	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	56,286	1,578,332	218,337	9,526	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	19,478	420,098	58,114	3,348	90.08
90.09	09009	PAIN MANAGEMENT	0	7,197	2,134	295	563	90.09
90.10	09010	DERMATOLOGY	0	22,229	233,094	32,245	3,522	90.10
90.11	09011	KIDS FIRST	0	58,241	1,229,285	170,052	10,464	90.11
91.00	09100	EMERGENCY	0	104,652	3,351,787	463,666	163,089	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	325,544	107,089	3,920,160	542,291	51,235	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	325,544	1,277,087	51,927,493	6,252,501	891,195	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17,938	2,481	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	77,934	2,725,708	377,058	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	17,817	631,146	87,309	0	194.01
194.02	07952	MOB	0	0	68,244	9,440	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	325,544	1,372,838	55,370,529	6,728,789	891,195	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.03	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,405,095					5.03
7.00	00700	OPERATION OF PLANT	0	2,362,234				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	23,064	360,926			8.00
9.00	00900	HOUSEKEEPING	0	49,400	0	1,077,865		9.00
10.00	01000	DIETARY	0	143,745	4,517	67,665	891,706	10.00
11.00	01100	CAFETERIA	0	71,809	0	33,803	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,086	0	5,689	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	80,194	0	37,750	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,834	0	2,276	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,274	545,973	76,386	257,007	665,957	30.00
31.00	03100	INTENSIVE CARE UNIT	6,786	72,942	66,846	34,336	71,266	31.00
43.00	04300	NURSERY	10,987	15,107	0	7,111	154,483	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	107,653	446,216	29,072	210,047	0	50.00
53.00	05300	ANESTHESIOLOGY	19,618	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	305,395	233,784	48,781	110,049	0	54.00
60.00	06000	LABORATORY	213,357	122,872	0	57,839	0	60.00
65.00	06500	RESPIRATORY THERAPY	22,667	26,740	0	12,587	0	65.00
66.00	06600	PHYSICAL THERAPY	25,701	90,467	0	42,586	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,716	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,454	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	86,387	45,926	9,048	21,619	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,291	109,678	0	51,629	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	24,083	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,251	30,869	0	14,531	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,149	19,136	0	9,008	0	90.00
90.01	09001	SENIOR CARE	2,750	0	24	0	0	90.01
90.02	09002	GENERAL SURGERY	1,556	0	420	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	7,177	0	0	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	6,673	0	152	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	7,718	0	47	0	0	90.05
90.06	09006	OBGYN - DR SAUER	2,310	0	897	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	15,019	0	738	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	5,278	0	181	0	0	90.08
90.09	09009	PAIN MANAGEMENT	888	0	1,339	0	0	90.09
90.10	09010	DERMATOLOGY	5,552	0	1,955	0	0	90.10
90.11	09011	KIDS FIRST	16,498	0	0	0	0	90.11
91.00	09100	EMERGENCY	257,129	184,282	100,179	86,747	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	80,778	0	19,132	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,405,095	2,329,124	359,714	1,062,279	891,706	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,521	0	9,660	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,212	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	12,589	0	5,926	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,405,095	2,362,234	360,926	1,077,865	891,706	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	711,766					11.00
13.00	01300	NURSING ADMINISTRATION	22,192	1,266,380				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,097	0	969,438			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,998	0	1,471	1,263,746		16.00
17.00	01700	SOCIAL SERVICE	8,694	0	177	0	576,098	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	162,061	574,109	19,111	62,301	430,250	30.00
31.00	03100	INTENSIVE CARE UNIT	23,348	82,713	6,515	6,103	46,042	31.00
43.00	04300	NURSERY	6,715	23,790	20	9,881	99,806	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,212	192,052	33,007	96,818	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,567	17,643	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,587	0	22,111	274,733	0	54.00
60.00	06000	LABORATORY	35,356	0	223,188	191,882	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	6,504	20,386	0	65.00
66.00	06600	PHYSICAL THERAPY	11,074	0	750	23,114	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,134	0	0	2,442	0	67.00
68.00	06800	SPEECH PATHOLOGY	245	0	0	1,308	0	68.00
69.00	06900	ELECTROCARDIOLOGY	18,078	64,044	3,685	77,692	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	352,423	29,940	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	179,245	21,659	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,938	0	2,935	58,684	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,201	4,254	116	1,033	0	90.00
90.01	09001	SENIOR CARE	3,135	11,107	399	2,474	0	90.01
90.02	09002	GENERAL SURGERY	13,164	0	1,052	1,399	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	20,480	0	5,349	6,454	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	15,276	0	3,523	6,001	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	22,014	0	5,319	6,941	0	90.05
90.06	09006	OBGYN - DR SAUER	7,516	0	6,250	2,078	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	39,492	0	9,603	13,507	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	13,764	0	4,616	4,747	0	90.08
90.09	09009	PAIN MANAGEMENT	1,001	0	249	799	0	90.09
90.10	09010	DERMATOLOGY	8,450	0	1,741	4,994	0	90.10
90.11	09011	KIDS FIRST	0	0	23,905	14,838	0	90.11
91.00	09100	EMERGENCY	88,723	314,311	30,247	231,248	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	23,360	72,647	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	678,945	1,266,380	969,438	1,263,746	576,098	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,851	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	21,970	0	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	711,766	1,266,380	969,438	1,263,746	576,098	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	MOB				1.01
1.02	00102	AMB DEPR				1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	AMB EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	ADMINISTRATIVE & GENERAL				5.01
5.02	00570	ADMITTING				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	9,513,274	0	9,513,274	30.00
31.00	03100	INTENSIVE CARE UNIT	1,296,407	0	1,296,407	31.00
43.00	04300	NURSERY	536,934	0	536,934	43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	3,627,133	0	3,627,133	50.00
53.00	05300	ANESTHESIOLOGY	70,643	0	70,643	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,969,836	0	3,969,836	54.00
60.00	06000	LABORATORY	4,494,561	0	4,494,561	60.00
65.00	06500	RESPIRATORY THERAPY	785,775	0	785,775	65.00
66.00	06600	PHYSICAL THERAPY	791,002	0	791,002	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,656	0	58,656	67.00
68.00	06800	SPEECH PATHOLOGY	15,152	0	15,152	68.00
69.00	06900	ELECTROCARDIOLOGY	1,226,553	0	1,226,553	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,984,634	0	2,984,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,398,389	0	1,398,389	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,079,616	0	3,079,616	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	100,929	0	100,929	90.00
90.01	09001	SENIOR CARE	287,655	0	287,655	90.01
90.02	09002	GENERAL SURGERY	494,902	0	494,902	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	838,173	0	838,173	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	606,597	0	606,597	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	745,069	0	745,069	90.05
90.06	09006	OBGYN - DR SAUER	307,012	0	307,012	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1,884,554	0	1,884,554	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	510,146	0	510,146	90.08
90.09	09009	PAIN MANAGEMENT	7,268	0	7,268	90.09
90.10	09010	DERMATOLOGY	291,553	0	291,553	90.10
90.11	09011	KIDS FIRST	1,465,042	0	1,465,042	90.11
91.00	09100	EMERGENCY	5,271,408	0	5,271,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	4,709,603	0	4,709,603	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,368,476	0	51,368,476	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	50,600	0	50,600	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,114,829	0	3,114,829	192.00
194.00	07950	MARKETING	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	758,940	0	758,940	194.01
194.02	07952	MOB	77,684	0	77,684	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	55,370,529	0	55,370,529	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,770	0	0	1,632	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	278,569	3,597	0	164,072	5.01
5.02	00570	ADMITTING	0	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	151,273	0	0	89,097	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,688	0	0	7,473	8.00
9.00	00900	HOUSEKEEPING	0	27,177	0	0	16,007	9.00
10.00	01000	DIETARY	0	79,079	0	0	46,576	10.00
11.00	01100	CAFETERIA	0	39,505	0	0	23,268	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,649	0	0	3,916	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44,117	0	0	25,984	16.00
17.00	01700	SOCIAL SERVICE	0	2,660	0	0	1,566	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	300,357	0	0	176,906	30.00
31.00	03100	INTENSIVE CARE UNIT	0	40,128	0	0	23,635	31.00
43.00	04300	NURSERY	0	8,311	0	0	4,895	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	245,478	0	0	144,582	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	128,612	0	0	75,750	54.00
60.00	06000	LABORATORY	0	67,596	0	0	39,813	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,710	0	0	8,664	65.00
66.00	06600	PHYSICAL THERAPY	0	49,769	0	0	29,313	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	25,265	0	0	14,881	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	60,338	0	0	35,538	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,982	0	0	10,002	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	10,527	0	0	6,200	90.00
90.01	09001	SENIOR CARE	0	0	20,974	0	0	90.01
90.02	09002	GENERAL SURGERY	0	0	13,946	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	0	63,124	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	0	80,649	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	0	96,576	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0	0	28,975	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	0	101,128	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	0	44,884	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0	0	22,020	0	0	90.09
90.10	09010	DERMATOLOGY	0	0	24,185	0	0	90.10
90.11	09011	KIDS FIRST	0	0	60,555	0	0	90.11
91.00	09100	EMERGENCY	0	101,380	0	0	59,711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	57,611	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,713,940	560,613	57,611	1,009,481	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,289	0	0	6,649	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	6,926	0	0	4,079	194.01
194.02	07952	MOB	0	0	68,244	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,732,155	628,857	57,611	1,020,209	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	ADMITTING	
			2.01	2A	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,402	4,402			4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	446,238	281	446,519		5.01
5.02	00570	ADMITTING	0	0	87	7,187	7,274	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	59	11,331	0	5.03
7.00	00700	OPERATION OF PLANT	0	240,370	47	19,050	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,161	5	2,725	0	8.00
9.00	00900	HOUSEKEEPING	0	43,184	76	8,294	0	9.00
10.00	01000	DIETARY	0	125,655	33	5,450	0	10.00
11.00	01100	CAFETERIA	0	62,773	42	4,888	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,565	114	9,890	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	33	7,712	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	70,101	91	8,970	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,226	56	4,517	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	477,263	645	53,271	360	30.00
31.00	03100	INTENSIVE CARE UNIT	0	63,763	77	7,058	35	31.00
43.00	04300	NURSERY	0	13,206	23	1,630	57	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	390,060	157	19,272	559	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	148	102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	204,362	168	22,038	1,563	54.00
60.00	06000	LABORATORY	0	107,409	144	28,344	1,108	60.00
65.00	06500	RESPIRATORY THERAPY	0	23,374	0	5,504	118	65.00
66.00	06600	PHYSICAL THERAPY	0	79,082	51	4,685	133	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5	408	14	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1	91	8	68.00
69.00	06900	ELECTROCARDIOLOGY	0	40,146	73	6,817	449	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	95,876	0	19,246	173	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	9,340	125	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,984	52	23,048	339	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	16,727	5	519	6	90.00
90.01	09001	SENIOR CARE	0	20,974	13	2,145	14	90.01
90.02	09002	GENERAL SURGERY	0	13,946	126	3,841	8	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	63,124	93	6,404	37	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	80,649	84	4,603	35	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	96,576	179	5,630	40	90.05
90.06	09006	OBGYN - DR SAUER	0	28,975	74	2,310	12	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	101,128	180	14,489	78	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	44,884	62	3,856	27	90.08
90.09	09009	PAIN MANAGEMENT	0	22,020	23	20	5	90.09
90.10	09010	DERMATOLOGY	0	24,185	71	2,140	29	90.10
90.11	09011	KIDS FIRST	0	60,555	187	11,285	86	90.11
91.00	09100	EMERGENCY	0	161,091	335	30,769	1,335	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	325,544	383,155	343	35,987	419	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	325,544	3,667,189	4,095	414,912	7,274	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,938	0	165	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	250	25,022	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	11,005	57	5,794	0	194.01
194.02	07952	MOB	0	68,244	0	626	0	194.02
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	325,544	3,764,376	4,402	446,519	7,274	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.03	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	11,390					5.03
7.00	00700	OPERATION OF PLANT	0	259,467				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,533	25,424			8.00
9.00	00900	HOUSEKEEPING	0	5,426	0	56,980		9.00
10.00	01000	DIETARY	0	15,789	318	3,577	150,822	10.00
11.00	01100	CAFETERIA	0	7,888	0	1,787	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,327	0	301	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,808	0	1,996	0	16.00
17.00	01700	SOCIAL SERVICE	0	531	0	120	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	563	59,970	5,381	13,586	112,639	30.00
31.00	03100	INTENSIVE CARE UNIT	55	8,012	4,709	1,815	12,054	31.00
43.00	04300	NURSERY	89	1,659	0	376	26,129	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	874	49,012	2,048	11,104	0	50.00
53.00	05300	ANESTHESIOLOGY	159	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,459	25,679	3,436	5,818	0	54.00
60.00	06000	LABORATORY	1,733	13,496	0	3,058	0	60.00
65.00	06500	RESPIRATORY THERAPY	184	2,937	0	665	0	65.00
66.00	06600	PHYSICAL THERAPY	209	9,937	0	2,251	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	22	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	702	5,044	637	1,143	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	270	12,047	0	2,729	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	196	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	530	3,391	0	768	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9	2,102	0	476	0	90.00
90.01	09001	SENIOR CARE	22	0	2	0	0	90.01
90.02	09002	GENERAL SURGERY	13	0	30	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	58	0	0	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	54	0	11	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	63	0	3	0	0	90.05
90.06	09006	OBGYN - DR SAUER	19	0	63	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	122	0	52	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	43	0	13	0	0	90.08
90.09	09009	PAIN MANAGEMENT	7	0	94	0	0	90.09
90.10	09010	DERMATOLOGY	45	0	138	0	0	90.10
90.11	09011	KIDS FIRST	134	0	0	0	0	90.11
91.00	09100	EMERGENCY	2,088	20,242	7,056	4,586	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	656	0	1,348	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,390	255,830	25,339	56,156	150,822	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,254	0	511	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	85	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	1,383	0	313	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,390	259,467	25,424	56,980	150,822	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	77,378					11.00
13.00	01300	NURSING ADMINISTRATION	2,413	24,610				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,424	0	9,169			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,479	0	14	93,459		16.00
17.00	01700	SOCIAL SERVICE	945	0	2	0	10,397	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,617	11,157	181	4,611	7,765	30.00
31.00	03100	INTENSIVE CARE UNIT	2,538	1,607	62	452	831	31.00
43.00	04300	NURSERY	730	462	0	731	1,801	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,894	3,732	312	7,166	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	24	1,306	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,282	0	209	20,253	0	54.00
60.00	06000	LABORATORY	3,844	0	2,110	14,203	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	62	1,509	0	65.00
66.00	06600	PHYSICAL THERAPY	1,204	0	7	1,711	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	123	0	0	181	0	67.00
68.00	06800	SPEECH PATHOLOGY	27	0	0	97	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,965	1,245	35	5,751	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,334	2,216	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,695	1,603	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	863	0	28	4,344	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	131	83	1	76	0	90.00
90.01	09001	SENIOR CARE	341	216	4	183	0	90.01
90.02	09002	GENERAL SURGERY	1,431	0	10	104	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	2,226	0	51	478	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	1,661	0	33	444	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	2,393	0	50	514	0	90.05
90.06	09006	OBGYN - DR SAUER	817	0	59	154	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	4,293	0	91	1,000	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	1,496	0	44	351	0	90.08
90.09	09009	PAIN MANAGEMENT	109	0	2	59	0	90.09
90.10	09010	DERMATOLOGY	919	0	16	370	0	90.10
90.11	09011	KIDS FIRST	0	0	226	1,098	0	90.11
91.00	09100	EMERGENCY	9,645	6,108	286	17,117	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	221	5,377	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,810	24,610	9,169	93,459	10,397	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,180	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	2,388	0	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	77,378	24,610	9,169	93,459	10,397	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	MOB				1.01
1.02	00102	AMB DEPR				1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	AMB EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	ADMINISTRATIVE & GENERAL				5.01
5.02	00570	ADMITTING				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	765,009	0	765,009	30.00
31.00	03100	INTENSIVE CARE UNIT	103,068	0	103,068	31.00
43.00	04300	NURSERY	46,893	0	46,893	43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	490,190	0	490,190	50.00
53.00	05300	ANESTHESIOLOGY	1,739	0	1,739	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	291,267	0	291,267	54.00
60.00	06000	LABORATORY	175,449	0	175,449	60.00
65.00	06500	RESPIRATORY THERAPY	34,353	0	34,353	65.00
66.00	06600	PHYSICAL THERAPY	99,270	0	99,270	66.00
67.00	06700	OCCUPATIONAL THERAPY	753	0	753	67.00
68.00	06800	SPEECH PATHOLOGY	236	0	236	68.00
69.00	06900	ELECTROCARDIOLOGY	64,007	0	64,007	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	135,891	0	135,891	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,959	0	12,959	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,347	0	60,347	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	20,135	0	20,135	90.00
90.01	09001	SENIOR CARE	23,914	0	23,914	90.01
90.02	09002	GENERAL SURGERY	19,509	0	19,509	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	72,471	0	72,471	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	87,574	0	87,574	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	105,448	0	105,448	90.05
90.06	09006	OBGYN - DR SAUER	32,483	0	32,483	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	121,433	0	121,433	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	50,776	0	50,776	90.08
90.09	09009	PAIN MANAGEMENT	22,339	0	22,339	90.09
90.10	09010	DERMATOLOGY	27,913	0	27,913	90.10
90.11	09011	KIDS FIRST	73,571	0	73,571	90.11
91.00	09100	EMERGENCY	260,658	0	260,658	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	427,506	0	427,506	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,627,161	0	3,627,161	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,868	0	20,868	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,537	0	26,537	192.00
194.00	07950	MARKETING	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	20,940	0	20,940	194.01
194.02	07952	MOB	68,870	0	68,870	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,764,376	0	3,764,376	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	
			1.00	1.01	1.02	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	125,051					1.00
1.01	00101	MOB	0	34,270				1.01
1.02	00102	AMB DEPR	0	0	11,032			1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				125,051		2.00
2.01	00201	AMB EQUIP				0	11,032	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	200	0	0	200	0	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	20,111	196	0	20,111	0	5.01
5.02	00570	ADMITTING	0	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	10,921	0	0	10,921	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	916	0	0	916	0	8.00
9.00	00900	HOUSEKEEPING	1,962	0	0	1,962	0	9.00
10.00	01000	DIETARY	5,709	0	0	5,709	0	10.00
11.00	01100	CAFETERIA	2,852	0	0	2,852	0	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0	16.00
17.00	01700	SOCIAL SERVICE	192	0	0	192	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,684	0	0	21,684	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	0	0	2,897	0	31.00
43.00	04300	NURSERY	600	0	0	600	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	0	0	17,722	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	0	0	9,285	0	54.00
60.00	06000	LABORATORY	4,880	0	0	4,880	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	0	1,062	0	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	0	3,593	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	0	0	1,824	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	0	1,226	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	760	0	0	760	0	90.00
90.01	09001	SENIOR CARE	0	1,143	0	0	0	90.01
90.02	09002	GENERAL SURGERY	0	760	0	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	3,440	0	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	4,395	0	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	5,263	0	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0	1,579	0	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	5,511	0	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	2,446	0	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0	1,200	0	0	0	90.09
90.10	09010	DERMATOLOGY	0	1,318	0	0	0	90.10
90.11	09011	KIDS FIRST	0	3,300	0	0	0	90.11
91.00	09100	EMERGENCY	7,319	0	0	7,319	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	11,032	0	11,032	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	123,736	30,551	11,032	123,736	11,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	0	500	0	194.01
194.02	07952	MOB	0	3,719	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,732,155	628,857	57,611	1,020,209	325,544	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.851589	18.350073	5.222172	8.158343	29.509065	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	
			1.00	1.01	1.02	2.00	2.01	
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			4.00	5A.01	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	29,925,808					4.00
5.01	00590	ADMINISTRATIVE & GENERAL	1,912,233	-6,728,789	48,641,740			5.01
5.02	00570	ADMITTING	593,700	0	782,894	187,082,080		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	404,327	0	1,234,343	0	187,082,080	5.03
7.00	00700	OPERATION OF PLANT	322,562	0	2,075,168	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37,219	0	296,804	0	0	8.00
9.00	00900	HOUSEKEEPING	516,595	0	903,483	0	0	9.00
10.00	01000	DIETARY	225,508	0	593,656	0	0	10.00
11.00	01100	CAFETERIA	285,616	0	532,492	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	774,236	0	1,077,375	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	226,947	0	840,123	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	621,022	0	977,159	0	0	16.00
17.00	01700	SOCIAL SERVICE	383,415	0	492,050	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,334,129	0	5,804,029	9,222,961	9,222,961	30.00
31.00	03100	INTENSIVE CARE UNIT	525,732	0	768,848	903,538	903,538	31.00
43.00	04300	NURSERY	156,987	0	177,509	1,462,745	1,462,745	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,064,629	0	2,099,362	14,332,742	14,332,742	50.00
53.00	05300	ANESTHESIOLOGY	0	0	16,139	2,611,890	2,611,890	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,146,239	0	2,400,619	40,670,059	40,670,059	54.00
60.00	06000	LABORATORY	977,494	0	3,087,618	28,405,883	28,405,883	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	599,573	3,017,896	3,017,896	65.00
66.00	06600	PHYSICAL THERAPY	346,792	0	510,403	3,421,755	3,421,755	66.00
67.00	06700	OCCUPATIONAL THERAPY	35,769	0	44,488	361,551	361,551	67.00
68.00	06800	SPEECH PATHOLOGY	7,927	0	9,859	193,617	193,617	68.00
69.00	06900	ELECTROCARDIOLOGY	497,050	0	742,560	11,501,410	11,501,410	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,096,536	4,432,259	4,432,259	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,017,388	3,206,393	3,206,393	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	356,118	0	2,510,705	8,687,426	8,687,426	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	33,810	0	56,489	152,996	152,996	90.00
90.01	09001	SENIOR CARE	88,600	0	233,694	366,182	366,182	90.01
90.02	09002	GENERAL SURGERY	856,228	0	418,440	207,169	207,169	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	633,774	0	697,652	955,476	955,476	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	571,025	0	501,381	888,440	888,440	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	1,218,667	0	613,295	1,027,597	1,027,597	90.05
90.06	09006	OBGYN - DR SAUER	506,123	0	251,680	307,593	307,593	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1,226,936	0	1,578,332	1,999,568	1,999,568	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	424,592	0	420,098	702,712	702,712	90.08
90.09	09009	PAIN MANAGEMENT	156,885	0	2,134	118,227	118,227	90.09
90.10	09010	DERMATOLOGY	484,549	0	233,094	739,238	739,238	90.10
90.11	09011	KIDS FIRST	1,269,556	0	1,229,285	2,196,552	2,196,552	90.11
91.00	09100	EMERGENCY	2,281,252	0	3,351,787	34,233,616	34,233,616	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,334,363	0	3,920,160	10,754,589	10,754,589	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,838,606	-6,728,789	45,198,704	187,082,080	187,082,080	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17,938	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,698,831	0	2,725,708	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	388,371	0	631,146	0	0	194.01
194.02	07952	MOB	0	0	68,244	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,372,838		6,728,789	891,195	1,405,095	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.045875		0.138334	0.004764	0.007511	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,402		446,519	7,274	11,390	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			4.00	5A.01	5.01	5.02	5.03	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000147		0.009180	0.000039	0.000061	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT	93,819					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	916	199,533				8.00
9.00	00900	HOUSEKEEPING	1,962	0	90,941			9.00
10.00	01000	DIETARY	5,709	2,497	5,709	4,029		10.00
11.00	01100	CAFETERIA	2,852	0	2,852	0	32,009	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	480	0	998	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	589	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	3,185	0	1,439	16.00
17.00	01700	SOCIAL SERVICE	192	0	192	0	391	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,684	42,229	21,684	3,009	7,288	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	36,955	2,897	322	1,050	31.00
43.00	04300	NURSERY	600	0	600	698	302	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	16,072	17,722	0	2,438	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	26,968	9,285	0	2,185	54.00
60.00	06000	LABORATORY	4,880	0	4,880	0	1,590	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	1,062	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	3,593	0	498	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	51	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	11	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	5,002	1,824	0	813	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	4,356	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	1,226	0	357	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	760	0	760	0	54	90.00
90.01	09001	SENIOR CARE	0	13	0	0	141	90.01
90.02	09002	GENERAL SURGERY	0	232	0	0	592	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	0	0	0	921	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	84	0	0	687	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	26	0	0	990	90.05
90.06	09006	OBGYN - DR SAUER	0	496	0	0	338	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	408	0	0	1,776	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	100	0	0	619	90.08
90.09	09009	PAIN MANAGEMENT	0	740	0	0	45	90.09
90.10	09010	DERMATOLOGY	0	1,081	0	0	380	90.10
90.11	09011	KIDS FIRST	0	0	0	0	0	90.11
91.00	09100	EMERGENCY	7,319	55,383	7,319	0	3,990	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	10,577	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,504	198,863	89,626	4,029	30,533	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	815	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	670	0	0	488	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	500	0	988	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,362,234	360,926	1,077,865	891,706	711,766	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.178631	1.808854	11.852355	221.321916	22.236434	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	259,467	25,424	56,980	150,822	77,378	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	
			7.00	8.00	9.00	10.00	11.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	2.765613	0.127418	0.626560	37.434103	2.417383	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			13.00	14.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	16,076					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,502,486				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,350	187,082,080			16.00
17.00	01700	SOCIAL SERVICE	0	1,006	0	4,029		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,288	108,472	9,222,961	3,009		30.00
31.00	03100	INTENSIVE CARE UNIT	1,050	36,978	903,538	322		31.00
43.00	04300	NURSERY	302	114	1,462,745	698		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,438	187,345	14,332,742	0		50.00
53.00	05300	ANESTHESIOLOGY	0	14,568	2,611,890	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	125,502	40,670,059	0		54.00
60.00	06000	LABORATORY	0	1,266,802	28,405,883	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	36,915	3,017,896	0		65.00
66.00	06600	PHYSICAL THERAPY	0	4,259	3,421,755	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	361,551	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	193,617	0		68.00
69.00	06900	ELECTROCARDIOLOGY	813	20,917	11,501,410	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,000,335	4,432,259	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,017,388	3,206,393	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,660	8,687,426	0		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	54	661	152,996	0		90.00
90.01	09001	SENIOR CARE	141	2,267	366,182	0		90.01
90.02	09002	GENERAL SURGERY	0	5,973	207,169	0		90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	30,363	955,476	0		90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	19,997	888,440	0		90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	30,191	1,027,597	0		90.05
90.06	09006	OBGYN - DR SAUER	0	35,473	307,593	0		90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	54,507	1,999,568	0		90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	26,199	702,712	0		90.08
90.09	09009	PAIN MANAGEMENT	0	1,414	118,227	0		90.09
90.10	09010	DERMATOLOGY	0	9,880	739,238	0		90.10
90.11	09011	KIDS FIRST	0	135,682	2,196,552	0		90.11
91.00	09100	EMERGENCY	3,990	171,680	34,233,616	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	132,588	10,754,589	0		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,076	5,502,486	187,082,080	4,029		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	MARKETING	0	0	0	0		194.00
194.01	07951	PHYSICIAN BILLING	0	0	0	0		194.01
194.02	07952	MOB	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,266,380	969,438	1,263,746	576,098		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	78.774571	0.176182	0.006755	142.987838		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,610	9,169	93,459	10,397		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 5:21 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			13.00	14.00	16.00	17.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	1.530853	0.001666	0.000500	2.580541		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,513,274		9,513,274	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,296,407		1,296,407	0	0	31.00
43.00	04300	NURSERY	536,934		536,934	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,627,133		3,627,133	0	0	50.00
53.00	05300	ANESTHESIOLOGY	70,643		70,643	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,969,836		3,969,836	0	0	54.00
60.00	06000	LABORATORY	4,494,561		4,494,561	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	785,775	0	785,775	0	0	65.00
66.00	06600	PHYSICAL THERAPY	791,002	0	791,002	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,656	0	58,656	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,152	0	15,152	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,226,553		1,226,553	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,984,634		2,984,634	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,398,389		1,398,389	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,079,616		3,079,616	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	100,929		100,929	0	0	90.00
90.01	09001	SENIOR CARE	287,655		287,655	0	0	90.01
90.02	09002	GENERAL SURGERY	494,902		494,902	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	838,173		838,173	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	606,597		606,597	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	745,069		745,069	0	0	90.05
90.06	09006	OBGYN - DR SAUER	307,012		307,012	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1,884,554		1,884,554	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	510,146		510,146	0	0	90.08
90.09	09009	PAIN MANAGEMENT	7,268		7,268	0	0	90.09
90.10	09010	DERMATOLOGY	291,553		291,553	0	0	90.10
90.11	09011	KIDS FIRST	1,465,042		1,465,042	0	0	90.11
91.00	09100	EMERGENCY	5,271,408		5,271,408	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,168,099		2,168,099		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,709,603		4,709,603	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	53,536,575	0	53,536,575	0	0	200.00
201.00		Less Observation Beds	2,168,099		2,168,099		0	201.00
202.00		Total (see instructions)	51,368,476	0	51,368,476	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,330,760		7,330,760			30.00
31.00	03100	INTENSIVE CARE UNIT	903,538		903,538			31.00
43.00	04300	NURSERY	1,462,745		1,462,745			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,735,250	11,597,492	14,332,742	0.253066	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	451,704	2,160,186	2,611,890	0.027047	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,362,328	39,307,731	40,670,059	0.097611	0.000000	54.00
60.00	06000	LABORATORY	3,561,149	24,844,734	28,405,883	0.158226	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	802,287	2,215,609	3,017,896	0.260372	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	560,490	2,861,265	3,421,755	0.231169	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	221,536	140,015	361,551	0.162234	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	90,768	102,849	193,617	0.078258	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	517,952	10,983,458	11,501,410	0.106644	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,492,563	2,939,696	4,432,259	0.673389	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,119,534	2,086,859	3,206,393	0.436125	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,196,922	6,490,504	8,687,426	0.354491	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,000	150,996	152,996	0.659684	0.000000	90.00
90.01	09001	SENIOR CARE	0	366,182	366,182	0.785552	0.000000	90.01
90.02	09002	GENERAL SURGERY	750	206,419	207,169	2.388881	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	250	955,226	955,476	0.877231	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	200	888,240	888,440	0.682766	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	1,500	1,026,097	1,027,597	0.725060	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	250	307,343	307,593	0.998111	0.000000	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	375	1,999,193	1,999,568	0.942481	0.000000	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	350	702,362	702,712	0.725967	0.000000	90.08
90.09	09009	PAIN MANAGEMENT	50	118,177	118,227	0.061475	0.000000	90.09
90.10	09010	DERMATOLOGY	3,500	735,738	739,238	0.394397	0.000000	90.10
90.11	09011	KIDS FIRST	350	2,196,202	2,196,552	0.666974	0.000000	90.11
91.00	09100	EMERGENCY	465,486	33,768,130	34,233,616	0.153983	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,892,201	1,892,201	1.145808	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	10,754,589	10,754,589	0.437916	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,284,587	161,797,493	187,082,080			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	25,284,587	161,797,493	187,082,080			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	SENIOR CARE	0.000000	90.01
90.02	09002	GENERAL SURGERY	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	0.000000	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0.000000	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.000000	90.08
90.09	09009	PAIN MANAGEMENT	0.000000	90.09
90.10	09010	DERMATOLOGY	0.000000	90.10
90.11	09011	KIDS FIRST	0.000000	90.11
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/26/2023 5:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,513,274		9,513,274	0	9,513,274	30.00
31.00	03100	INTENSIVE CARE UNIT	1,296,407		1,296,407	0	1,296,407	31.00
43.00	04300	NURSERY	536,934		536,934	0	536,934	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,627,133		3,627,133	0	3,627,133	50.00
53.00	05300	ANESTHESIOLOGY	70,643		70,643	0	70,643	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,969,836		3,969,836	0	3,969,836	54.00
60.00	06000	LABORATORY	4,494,561		4,494,561	0	4,494,561	60.00
65.00	06500	RESPIRATORY THERAPY	785,775	0	785,775	0	785,775	65.00
66.00	06600	PHYSICAL THERAPY	791,002	0	791,002	0	791,002	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,656	0	58,656	0	58,656	67.00
68.00	06800	SPEECH PATHOLOGY	15,152	0	15,152	0	15,152	68.00
69.00	06900	ELECTROCARDIOLOGY	1,226,553		1,226,553	0	1,226,553	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,984,634		2,984,634	0	2,984,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,398,389		1,398,389	0	1,398,389	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,079,616		3,079,616	0	3,079,616	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	100,929		100,929	0	100,929	90.00
90.01	09001	SENIOR CARE	287,655		287,655	0	287,655	90.01
90.02	09002	GENERAL SURGERY	494,902		494,902	0	494,902	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	838,173		838,173	0	838,173	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	606,597		606,597	0	606,597	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	745,069		745,069	0	745,069	90.05
90.06	09006	OBGYN - DR SAUER	307,012		307,012	0	307,012	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	1,884,554		1,884,554	0	1,884,554	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	510,146		510,146	0	510,146	90.08
90.09	09009	PAIN MANAGEMENT	7,268		7,268	0	7,268	90.09
90.10	09010	DERMATOLOGY	291,553		291,553	0	291,553	90.10
90.11	09011	KIDS FIRST	1,465,042		1,465,042	0	1,465,042	90.11
91.00	09100	EMERGENCY	5,271,408		5,271,408	0	5,271,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,168,099		2,168,099		2,168,099	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,709,603		4,709,603	0	4,709,603	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	53,536,575	0	53,536,575	0	53,536,575	200.00
201.00		Less Observation Beds	2,168,099		2,168,099		2,168,099	201.00
202.00		Total (see instructions)	51,368,476	0	51,368,476	0	51,368,476	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/26/2023 5:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,330,760		7,330,760			30.00
31.00	03100	INTENSIVE CARE UNIT	903,538		903,538			31.00
43.00	04300	NURSERY	1,462,745		1,462,745			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,735,250	11,597,492	14,332,742	0.253066	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	451,704	2,160,186	2,611,890	0.027047	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,362,328	39,307,731	40,670,059	0.097611	0.000000	54.00
60.00	06000	LABORATORY	3,561,149	24,844,734	28,405,883	0.158226	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	802,287	2,215,609	3,017,896	0.260372	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	560,490	2,861,265	3,421,755	0.231169	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	221,536	140,015	361,551	0.162234	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	90,768	102,849	193,617	0.078258	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	517,952	10,983,458	11,501,410	0.106644	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,492,563	2,939,696	4,432,259	0.673389	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,119,534	2,086,859	3,206,393	0.436125	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,196,922	6,490,504	8,687,426	0.354491	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,000	150,996	152,996	0.659684	0.000000	90.00
90.01	09001	SENIOR CARE	0	366,182	366,182	0.785552	0.000000	90.01
90.02	09002	GENERAL SURGERY	750	206,419	207,169	2.388881	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	250	955,226	955,476	0.877231	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	200	888,240	888,440	0.682766	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	1,500	1,026,097	1,027,597	0.725060	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	250	307,343	307,593	0.998111	0.000000	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	375	1,999,193	1,999,568	0.942481	0.000000	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	350	702,362	702,712	0.725967	0.000000	90.08
90.09	09009	PAIN MANAGEMENT	50	118,177	118,227	0.061475	0.000000	90.09
90.10	09010	DERMATOLOGY	3,500	735,738	739,238	0.394397	0.000000	90.10
90.11	09011	KIDS FIRST	350	2,196,202	2,196,552	0.666974	0.000000	90.11
91.00	09100	EMERGENCY	465,486	33,768,130	34,233,616	0.153983	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,892,201	1,892,201	1.145808	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	10,754,589	10,754,589	0.437916	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,284,587	161,797,493	187,082,080			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	25,284,587	161,797,493	187,082,080			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/26/2023 5:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	SENIOR CARE	0.000000	90.01
90.02	09002	GENERAL SURGERY	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	0.000000	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0.000000	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.000000	90.08
90.09	09009	PAIN MANAGEMENT	0.000000	90.09
90.10	09010	DERMATOLOGY	0.000000	90.10
90.11	09011	KIDS FIRST	0.000000	90.11
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	490,190	14,332,742	0.034201	350,643	11,992	50.00
53.00	05300	ANESTHESIOLOGY	1,739	2,611,890	0.000666	63,441	42	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	291,267	40,670,059	0.007162	275,221	1,971	54.00
60.00	06000	LABORATORY	175,449	28,405,883	0.006177	742,426	4,586	60.00
65.00	06500	RESPIRATORY THERAPY	34,353	3,017,896	0.011383	307,630	3,502	65.00
66.00	06600	PHYSICAL THERAPY	99,270	3,421,755	0.029011	215,581	6,254	66.00
67.00	06700	OCCUPATIONAL THERAPY	753	361,551	0.002083	71,951	150	67.00
68.00	06800	SPEECH PATHOLOGY	236	193,617	0.001219	12,053	15	68.00
69.00	06900	ELECTROCARDIOLOGY	64,007	11,501,410	0.005565	258,813	1,440	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	135,891	4,432,259	0.030660	493,560	15,133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,959	3,206,393	0.004042	435,027	1,758	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,347	8,687,426	0.006946	750,414	5,212	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,135	152,996	0.131605	1,704	224	90.00
90.01	09001	SENIOR CARE	23,914	366,182	0.065306	0	0	90.01
90.02	09002	GENERAL SURGERY	19,509	207,169	0.094169	657	62	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	72,471	955,476	0.075848	162	12	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	87,574	888,440	0.098571	148	15	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	105,448	1,027,597	0.102616	1,372	141	90.05
90.06	09006	OBGYN - DR SAUER	32,483	307,593	0.105604	242	26	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	121,433	1,999,568	0.060730	369	22	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	50,776	702,712	0.072257	235	17	90.08
90.09	09009	PAIN MANAGEMENT	22,339	118,227	0.188950	13	2	90.09
90.10	09010	DERMATOLOGY	27,913	739,238	0.037759	3,249	123	90.10
90.11	09011	KIDS FIRST	73,571	2,196,552	0.033494	298	10	90.11
91.00	09100	EMERGENCY	260,658	34,233,616	0.007614	16,134	123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	174,348	1,892,201	0.092140	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,459,033	166,630,448		4,001,343	52,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
90.02	09002	GENERAL SURGERY	0	0	0	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	0	0	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	0	0	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0	0	0	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	0	0	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	0	0	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0	0	0	0	0	90.09
90.10	09010	DERMATOLOGY	0	0	0	0	0	90.10
90.11	09011	KIDS FIRST	0	0	0	0	0	90.11
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	14,332,742	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,611,890	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	40,670,059	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	28,405,883	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,017,896	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,421,755	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	361,551	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	193,617	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	11,501,410	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,432,259	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,206,393	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,687,426	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	152,996	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	366,182	0.000000	90.01
90.02	09002	GENERAL SURGERY	0	0	0	207,169	0.000000	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0	0	0	955,476	0.000000	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0	0	0	888,440	0.000000	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0	0	0	1,027,597	0.000000	90.05
90.06	09006	OBGYN - DR SAUER	0	0	0	307,593	0.000000	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	0	0	1,999,568	0.000000	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	0	0	702,712	0.000000	90.08
90.09	09009	PAIN MANAGEMENT	0	0	0	118,227	0.000000	90.09
90.10	09010	DERMATOLOGY	0	0	0	739,238	0.000000	90.10
90.11	09011	KIDS FIRST	0	0	0	2,196,552	0.000000	90.11
91.00	09100	EMERGENCY	0	0	0	34,233,616	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,892,201	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	166,630,448		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	350,643	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	63,441	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	275,221	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	742,426	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	307,630	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	215,581	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	71,951	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	12,053	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	258,813	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	493,560	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	435,027	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	750,414	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	1,704	0	0	0	90.00
90.01	09001	SENIOR CARE	0.000000	0	0	0	0	90.01
90.02	09002	GENERAL SURGERY	0.000000	657	0	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.000000	162	0	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.000000	148	0	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.000000	1,372	0	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0.000000	242	0	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0.000000	369	0	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.000000	235	0	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.000000	13	0	0	0	90.09
90.10	09010	DERMATOLOGY	0.000000	3,249	0	0	0	90.10
90.11	09011	KIDS FIRST	0.000000	298	0	0	0	90.11
91.00	09100	EMERGENCY	0.000000	16,134	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,001,343	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.253066	0	2,049,795	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.027047	0	391,487	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097611	0	9,189,062	0	0	54.00
60.00	06000	LABORATORY	0.158226	0	5,682,108	3	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.260372	0	727,536	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.231169	0	700,258	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.162234	0	43,050	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.078258	0	27,531	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.106644	0	3,191,804	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.673389	0	479,117	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.436125	0	498,878	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.354491	0	3,227,985	17,575	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.659684	0	30,511	0	0	90.00
90.01	09001	SENIOR CARE	0.785552	0	215,513	0	0	90.01
90.02	09002	GENERAL SURGERY	2.388881	0	11,699	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.877231	0	5,519	143	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.682766	0	69,980	76	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.725060	0	24,290	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0.998111	0	4,518	146	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0.942481	0	7,124	347	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.725967	0	7,252	169	0	90.08
90.09	09009	PAIN MANAGEMENT	0.061475	0	184	0	0	90.09
90.10	09010	DERMATOLOGY	0.394397	0	57,943	0	0	90.10
90.11	09011	KIDS FIRST	0.666974	0	15,736	5,813	0	90.11
91.00	09100	EMERGENCY	0.153983	0	6,573,217	2,663	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.145808	0	657,678	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.437916		0			95.00
200.00		Subtotal (see instructions)		0	33,889,775	26,935	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	33,889,775	26,935	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	518,733	0	50.00
53.00	05300	ANESTHESIOLOGY	10,589	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	896,954	0	54.00
60.00	06000	LABORATORY	899,057	0	60.00
65.00	06500	RESPIRATORY THERAPY	189,430	0	65.00
66.00	06600	PHYSICAL THERAPY	161,878	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,984	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,155	0	68.00
69.00	06900	ELECTROCARDIOLOGY	340,387	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	322,632	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	217,573	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,144,292	6,230	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	20,128	0	90.00
90.01	09001	SENIOR CARE	169,297	0	90.01
90.02	09002	GENERAL SURGERY	27,948	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	4,841	125	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	47,780	52	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	17,612	0	90.05
90.06	09006	OBGYN - DR SAUER	4,509	146	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	6,714	327	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	5,265	123	90.08
90.09	09009	PAIN MANAGEMENT	11	0	90.09
90.10	09010	DERMATOLOGY	22,853	0	90.10
90.11	09011	KIDS FIRST	10,496	3,877	90.11
91.00	09100	EMERGENCY	1,012,164	410	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	753,573	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	6,813,855	11,290	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	6,813,855	11,290	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V | Date/Time Prepared: 5/26/2023 5:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.253066	0	116,879	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.027047	0	99,385	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097611	0	585,216	0	0	54.00
60.00	06000	LABORATORY	0.158226	0	434,238	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.260372	0	45,822	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.231169	0	13,971	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.162234	0	375	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.078258	0	6,527	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.106644	0	56,096	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.673389	0	40,604	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.436125	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.354491	0	114,353	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.659684	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.785552	0	0	0	0	90.01
90.02	09002	GENERAL SURGERY	2.388881	0	3,775	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.877231	0	14,571	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.682766	0	3,802	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.725060	0	28,065	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0.998111	0	37,579	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0.942481	0	0	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.725967	0	0	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.061475	0	0	0	0	90.09
90.10	09010	DERMATOLOGY	0.394397	0	0	0	0	90.10
90.11	09011	KIDS FIRST	0.666974	0	0	0	0	90.11
91.00	09100	EMERGENCY	0.153983	0	734,527	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.145808	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.437916	0	295,934			95.00
200.00		Subtotal (see instructions)		0	2,631,719	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	2,631,719	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 5:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	29,578	0	50.00
53.00	05300	ANESTHESIOLOGY	2,688	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,124	0	54.00
60.00	06000	LABORATORY	68,708	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,931	0	65.00
66.00	06600	PHYSICAL THERAPY	3,230	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	61	0	67.00
68.00	06800	SPEECH PATHOLOGY	511	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,982	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,342	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,537	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	SENIOR CARE	0	0	90.01
90.02	09002	GENERAL SURGERY	9,018	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	12,782	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	2,596	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	20,349	0	90.05
90.06	09006	OBGYN - DR SAUER	37,508	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0	0	90.09
90.10	09010	DERMATOLOGY	0	0	90.10
90.11	09011	KIDS FIRST	0	0	90.11
91.00	09100	EMERGENCY	113,105	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	129,594		95.00
200.00		Subtotal (see instructions)	572,644	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	572,644	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,971	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,914	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,009	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	57	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	854	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	57	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	250.44	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,513,274	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	136,554	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,376,720	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,376,720	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,395.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,045,919	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,045,919	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,296,407	322	4,026.11	84	338,193	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,201,695	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	3,585,807	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	136,554	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	136,554	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	905	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,395.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,168,099	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 5:21 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	765,009	9,513,274	0.080415	2,168,099	174,348	90.00
91.00	Nursing Program cost	0	9,513,274	0.000000	2,168,099	0	91.00
92.00	Allied health cost	0	9,513,274	0.000000	2,168,099	0	92.00
93.00	All other Medical Education	0	9,513,274	0.000000	2,168,099	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 5:21 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,971	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,914	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,009	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	57	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	84	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	698	15.00
16.00	Nursery days (title V or XIX only)	20	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	250.44	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,513,274	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	136,554	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,376,720	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,376,720	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,395.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	201,238	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	201,238	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 5:21 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	536,934	698	769.25	20	15,385	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,296,407	322	4,026.11	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	76,819	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	293,442	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	905	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,395.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,168,099	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 5:21 pm
	Title XIX	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	765,009	9,513,274	0.080415	2,168,099	174,348	90.00
91.00	Nursing Program cost	0	9,513,274	0.000000	2,168,099	0	91.00
92.00	Allied health cost	0	9,513,274	0.000000	2,168,099	0	92.00
93.00	All other Medical Education	0	9,513,274	0.000000	2,168,099	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/26/2023 5:21 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,311,204		30.00
31.00	03100	INTENSIVE CARE UNIT		245,196		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.253066	350,643	88,736	50.00
53.00	05300	ANESTHESIOLOGY	0.027047	63,441	1,716	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097611	275,221	26,865	54.00
60.00	06000	LABORATORY	0.158226	742,426	117,471	60.00
65.00	06500	RESPIRATORY THERAPY	0.260372	307,630	80,098	65.00
66.00	06600	PHYSICAL THERAPY	0.231169	215,581	49,836	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.162234	71,951	11,673	67.00
68.00	06800	SPEECH PATHOLOGY	0.078258	12,053	943	68.00
69.00	06900	ELECTROCARDIOLOGY	0.106644	258,813	27,601	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.673389	493,560	332,358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.436125	435,027	189,726	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.354491	750,414	266,015	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.659684	1,704	1,124	90.00
90.01	09001	SENIOR CARE	0.785552	0	0	90.01
90.02	09002	GENERAL SURGERY	2.388881	657	1,569	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.877231	162	142	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.682766	148	101	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.725060	1,372	995	90.05
90.06	09006	OBGYN - DR SAUER	0.998111	242	242	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0.942481	369	348	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.725967	235	171	90.08
90.09	09009	PAIN MANAGEMENT	0.061475	13	1	90.09
90.10	09010	DERMATOLOGY	0.394397	3,249	1,281	90.10
90.11	09011	KIDS FIRST	0.666974	298	199	90.11
91.00	09100	EMERGENCY	0.153983	16,134	2,484	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.145808	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,001,343	1,201,695	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,001,343		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1331 Component CCN: 15-Z331	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/26/2023 5:21 pm
	Title XVIII	Swing Beds - SNF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.253066	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.027047	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097611	0	0	54.00
60.00	06000	LABORATORY	0.158226	3,412	540	60.00
65.00	06500	RESPIRATORY THERAPY	0.260372	502	131	65.00
66.00	06600	PHYSICAL THERAPY	0.231169	26,716	6,176	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.162234	15,954	2,588	67.00
68.00	06800	SPEECH PATHOLOGY	0.078258	3,282	257	68.00
69.00	06900	ELECTROCARDIOLOGY	0.106644	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.673389	13,006	8,758	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.436125	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.354491	10,950	3,882	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.659684	0	0	90.00
90.01	09001	SENIOR CARE	0.785552	0	0	90.01
90.02	09002	GENERAL SURGERY	2.388881	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.877231	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.682766	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.725060	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0.998111	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0.942481	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.725967	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.061475	0	0	90.09
90.10	09010	DERMATOLOGY	0.394397	0	0	90.10
90.11	09011	KIDS FIRST	0.666974	0	0	90.11
91.00	09100	EMERGENCY	0.153983	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.145808	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		73,822	22,332	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		73,822		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 5:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		447,771		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		111,380		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.253066	17,354	4,392	50.00
53.00	05300	ANESTHESIOLOGY	0.027047	1,243	34	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097611	44,311	4,325	54.00
60.00	06000	LABORATORY	0.158226	123,209	19,495	60.00
65.00	06500	RESPIRATORY THERAPY	0.260372	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.231169	8,986	2,077	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.162234	6,230	1,011	67.00
68.00	06800	SPEECH PATHOLOGY	0.078258	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.106644	19,753	2,107	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.673389	8,212	5,530	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.436125	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.354491	90,337	32,024	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.659684	0	0	90.00
90.01	09001	SENIOR CARE	0.785552	0	0	90.01
90.02	09002	GENERAL SURGERY	2.388881	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.877231	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.682766	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.725060	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0.998111	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0.942481	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.725967	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.061475	0	0	90.09
90.10	09010	DERMATOLOGY	0.394397	0	0	90.10
90.11	09011	KIDS FIRST	0.666974	0	0	90.11
91.00	09100	EMERGENCY	0.153983	37,822	5,824	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.145808	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		357,457	76,819	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		357,457		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 5:21 pm

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.253066	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.027047	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097611	0	0	54.00
60.00	06000	LABORATORY	0.158226	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.260372	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.231169	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.162234	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.078258	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.106644	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.673389	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.436125	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.354491	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.659684	0	0	90.00
90.01	09001	SENIOR CARE	0.785552	0	0	90.01
90.02	09002	GENERAL SURGERY	2.388881	0	0	90.02
90.03	09003	HARRISON CRAWFORD HEALTHCARE	0.877231	0	0	90.03
90.04	09004	CORYDON MEDICAL ASSOCIATES	0.682766	0	0	90.04
90.05	09005	ORTHOPEDIC SURGERY - DR KLINE	0.725060	0	0	90.05
90.06	09006	OBGYN - DR SAUER	0.998111	0	0	90.06
90.07	09007	FIRST CAPITAL MEDICAL GROUP	0.942481	0	0	90.07
90.08	09008	SOUTH HARRISON FAMILY MEDICINE	0.725967	0	0	90.08
90.09	09009	PAIN MANAGEMENT	0.061475	0	0	90.09
90.10	09010	DERMATOLOGY	0.394397	0	0	90.10
90.11	09011	KIDS FIRST	0.666974	0	0	90.11
91.00	09100	EMERGENCY	0.153983	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.145808	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part B Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,825,145	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,825,145	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,893,396	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	95,950	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,492,219	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,305,227	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,305,227	30.00
31.00	Primary payer payments	1,241	31.00
32.00	Subtotal (line 30 minus line 31)	1,303,986	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	795,451	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	517,043	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	432,652	36.00
37.00	Subtotal (see instructions)	1,821,029	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,821,029	40.00
40.01	Sequestration adjustment (see instructions)	22,945	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	1,972,703	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-174,619	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	278,408	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 5:21 pm
	Title XVIII	Hospital	Cost

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,784,782		1,972,703	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,784,782		1,972,703	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		517,372		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		174,619	6.02
7.00	Total Medicare program liability (see instructions)		3,302,154		1,798,084	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2023 5:21 pm

Component CCN: 15-Z331

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		148,532		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		148,532		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		9,921		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		158,453		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/26/2023 5:21 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	137,920	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	22,555	0	3.00
3.01	Nursing and allied health payment-PARHM or CHART (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	57	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	160,475	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	160,475	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	160,475	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	160,475	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	160,475	0	19.00
19.01	Sequestration adjustment (see instructions)	2,022	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM or CHART pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	148,532	0	20.00
20.01	Interim payments-PARHM or CHART			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM or CHART (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	9,921	0	22.00
22.01	Balance due provider/program-PARHM or CHART (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/26/2023 5:21 pm

Title XIX | Swing Beds - SNF | Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-3 Part V Date/Time Prepared: 5/26/2023 5:21 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,585,807	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	3,585,807	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,621,665	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,621,665	19.00
20.00	Deductibles (exclude professional component)	301,648	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,320,017	22.00
23.00	Coinsurance	6,224	23.00
24.00	Subtotal (line 22 minus line 23)	3,313,793	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	46,922	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	30,499	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,506	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,344,292	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,344,292	30.00
30.01	Sequestration adjustment (see instructions)	42,138	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM or CHART		30.03
31.00	Interim payments	2,784,782	31.00
31.01	Interim payments-PARHM or CHART		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	517,372	33.00
33.01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	16,423	34.00

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

Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/26/2023 5:21 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,195,526	0	0	0	1.00
2.00	Temporary investments	640,135	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	27,919,665	0	0	0	4.00
5.00	Other receivable	2,388,974	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-22,205,463	0	0	0	6.00
7.00	Inventory	1,369,026	0	0	0	7.00
8.00	Prepaid expenses	1,364,825	0	0	0	8.00
9.00	Other current assets	1,153,765	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,826,453	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,001,138	0	0	0	12.00
13.00	Land improvements	3,310,462	0	0	0	13.00
14.00	Accumulated depreciation	-2,642,838	0	0	0	14.00
15.00	Buildings	42,421,847	0	0	0	15.00
16.00	Accumulated depreciation	-27,917,775	0	0	0	16.00
17.00	Leasehold improvements	4,243,870	0	0	0	17.00
18.00	Accumulated depreciation	-2,669,545	0	0	0	18.00
19.00	Fixed equipment	346,074	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	25,239,972	0	0	0	23.00
24.00	Accumulated depreciation	-22,749,626	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,583,579	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	4,849,275	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	-1,153,765	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,695,510	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	40,105,542	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,887,995	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,141,859	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,395,671	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,425,525	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,463,633	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,463,633	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,889,158	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	27,216,384				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	27,216,384	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	40,105,542	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/26/2023 5:21 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		32,609,486		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,393,102				2.00
3.00	Total (sum of line 1 and line 2)		27,216,384		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		27,216,384		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		27,216,384		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2023 5:21 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,359,025		7,359,025	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,359,025		7,359,025	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	938,978		938,978	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	938,978		938,978	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,298,003		8,298,003	17.00
18.00	Ancillary services	16,624,554	159,959,928	176,584,482	18.00
19.00	Outpatient services	0	8,320	8,320	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	10,754,589	10,754,589	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	24,922,557	170,722,837	195,645,394	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		64,606,803		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		64,606,803		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1331	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 5/26/2023 5:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	195,645,394	1.00
2.00	Less contractual allowances and discounts on patients' accounts	138,963,456	2.00
3.00	Net patient revenues (line 1 minus line 2)	56,681,938	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	64,606,803	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,924,865	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	3,218	6.00
7.00	Income from investments	35,888	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	123,025	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	23,046	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	213,978	22.00
23.00	Governmental appropriations	34,285	23.00
24.00	MISC INCOME	2,098,323	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	2,531,763	25.00
26.00	Total (line 5 plus line 25)	-5,393,102	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-5,393,102	29.00