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: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/31/2024 7:01 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/31/2024 Time: 7:01 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "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 HANCOCK REGIONAL HOSPITAL (15-0037) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		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	197,540	-22,982	0	-329,828	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		4,267		0	10.00
200.00	TOTAL	0	197,540	-18,715	0	-329,828	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: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2024 7:01 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 801 NORTH STATE STREET	PO Box:			1.00
2.00	City: GREENFIELD	State: IN	Zip Code: 46140-	County: HANCOCK	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HANCOCK REGIONAL HOSPITAL	150037	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	KNIGHTSTOWN RURAL HEALTH	153987	26900		09/22/1998	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim 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)	Y	Y		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.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 7:01 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	160	49	7	0	1,740	34	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 7:01 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

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

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

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

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

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

		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.	N	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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 7:01 am

		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?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	320,190	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
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.	Y	N	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

Line	Description	1.00	Line
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

Line	Description	Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00	Line
	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

Line	Description	1.00	Line
	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

Line	Description	Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00	Line
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

Line	Description	1.00	Line
	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

Line	Description	Beginning 1.00	Ending 2.00	Line
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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 7:01 am

		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	A	07/30/2024	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.	Y		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or 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	04/02/2024	Y	04/02/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 7:01 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 7:01 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2024 7:01 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH 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	87	31,755	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		87	31,755	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	26	9,490	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		113	41,245	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	7	2,555			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		120				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: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 7:01 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	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)	935	160	5,011			1.00
2.00	HMO and other (see instructions)	3,895	1,796				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	935	160	5,011			7.00
8.00	INTENSIVE CARE UNIT	1,858	0	6,140			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	2,793	160	11,151	0.00	812.43	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	314	0.00	7.81	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	375	0	4,015	0.00	4.00	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	824.24	27.00
28.00	Observation Bed Days		0	3,662			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			74			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	34	72			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: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2024 7:01 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	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	734	52	2,817	1.00
2.00	HMO and other (see instructions)			820	646		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	734	52	2,817	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2024 7:01 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	73,306,400	-242,411	73,063,989	1,609,053.00	45.41	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		3,795,733	0	3,795,733	26,653.00	142.41	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		115,241	0	115,241	6,337.00	18.19	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		18,420,246	-503,679	17,916,567	292,375.00	61.28	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,947,108	0	2,947,108	30,505.00	96.61	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		32,695	0	32,695	467.00	70.01	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		12,172,351	0	12,172,351			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		3,055,082	0	3,055,082			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		453,228	0	453,228			23.00
24.00	Wage-related costs (RHC/FQHC)		42,792	0	42,792			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2024 7:01 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	642,288	-8,577	633,711	20,059.00	31.59	26.00
27.00	Administrative & General	5.00	11,141,428	-316,038	10,825,390	252,445.00	42.88	27.00
28.00	Administrative & General under contract (see inst.)		283,468	0	283,468	1,186.00	239.01	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,234,551	-34,071	1,200,480	30,353.00	39.55	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	2,004,405	-1,949	2,002,456	94,474.00	21.20	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,722,956	-1,065,903	657,053	30,194.00	21.76	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,059,492	1,059,492	41,010.00	25.83	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,461,219	0	1,461,219	24,159.00	60.48	38.00
39.00	Central Services and Supply	14.00	325,761	-6,417	319,344	8,314.00	38.41	39.00
40.00	Pharmacy	15.00	2,685,772	-2,836	2,682,936	55,621.00	48.24	40.00
41.00	Medical Records & Medical Records Library	16.00	733,457	0	733,457	27,311.00	26.86	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2024 7:01 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		69,678,894	-242,411	69,436,483	1,577,249.00	44.02	1.00
2.00	Excluded area salaries (see instructions)		18,420,246	-503,679	17,916,567	292,375.00	61.28	2.00
3.00	Subtotal salaries (line 1 minus line 2)		51,258,648	261,268	51,519,916	1,284,874.00	40.10	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,979,803	0	2,979,803	30,972.00	96.21	4.00
5.00	Subtotal wage-related costs (see inst.)		12,172,351	0	12,172,351	0.00	23.63	5.00
6.00	Total (sum of lines 3 thru 5)		66,410,802	261,268	66,672,070	1,315,846.00	50.67	6.00
7.00	Total overhead cost (see instructions)		22,235,305	-376,299	21,859,006	585,126.00	37.36	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/31/2024 7:01 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	3,027,052	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	655	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6,547,722	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	513,300	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	273,916	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	425,165	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	-1,608	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	4,805,789	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	1,950	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	-6	21.00
22.00	Day Care Cost and Allowances	28,600	22.00
23.00	Tuition Reimbursement	100,918	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,723,453	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V Date/Time Prepared: 5/31/2024 7:01 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2,947,108	15,723,453	1.00
2.00	Hospital	2,947,108	15,723,453	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/31/2024 7:01 am

RHC I | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	224 WEST MAIN STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	KNIGHTSTOWN	IN	46146	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	137632	07/01/2015	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

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

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.	N	0	13.01

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/31/2024 7:01 am
		RHC I	Cost

		County	
		4.00	
2.00	City, State, ZIP Code, County	HANCOCK	2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 7:01 am

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.224900	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	9,602,644	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	70,672,903	6.00
7.00	Medicaid cost (line 1 times line 6)	15,894,336	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	6,291,692	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 (see instructions)	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 (see instructions)	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)	6,291,692	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	3,702,669	1,518,821	5,221,490	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	832,730	1,518,821	2,351,551	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 (see instructions)	832,730	1,518,821	2,351,551	23.00

		1.00	
24.00	Does the amount on line 20 col. 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
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	10,726,482	26.00
27.00	Medicare reimbursable bad debts (see instructions)	49,954	27.00
27.01	Medicare allowable bad debts (see instructions)	76,853	27.01
28.00	Non-Medicare bad debt amount (see instructions)	10,649,629	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	2,422,001	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	4,773,552	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	11,065,244	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/31/2024 7:01 am

Line	Description	1.00	Line
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.224263	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		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)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		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		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

Line	Description	Uninsured patients 1.00	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	Line
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	3,702,669	1,518,821	5,221,490	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	830,372	1,518,821	2,349,193	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 (see instructions)	830,372	1,518,821	2,349,193	23.00

Line	Description	1.00	Line
24.00	Does the amount on line 20 col. 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
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	10,726,482	26.00
27.00	Medicare reimbursable bad debts (see instructions)	49,954	27.00
27.01	Medicare allowable bad debts (see instructions)	76,853	27.01
28.00	Non-Medicare bad debt amount (see instructions)	10,649,629	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	2,415,217	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	4,764,410	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,764,410	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		17,980,420	17,980,420	0	17,980,420	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	642,288	11,392,123	12,034,411	-53,354	11,981,057	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,141,428	27,738,792	38,880,220	-1,100,482	37,779,738	5.00
7.00	00700	OPERATION OF PLANT	1,234,551	6,379,801	7,614,352	2,060	7,616,412	7.00
9.00	00900	HOUSEKEEPING	2,004,405	1,016,726	3,021,131	0	3,021,131	9.00
10.00	01000	DIETARY	1,722,956	1,629,366	3,352,322	-1,919,875	1,432,447	10.00
11.00	01100	CAFETERIA	0	0	0	1,919,875	1,919,875	11.00
13.00	01300	NURSING ADMINISTRATION	1,461,219	366,434	1,827,653	-53	1,827,600	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	325,761	104,140	429,901	-1,845	428,056	14.00
15.00	01500	PHARMACY	2,685,772	22,191,596	24,877,368	-21,101,466	3,775,902	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	733,457	557,386	1,290,843	6,693	1,297,536	16.00
23.00	02300	PARAMED ED PRGM	98,083	18,797	116,880	0	116,880	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,685,952	1,924,433	5,610,385	644,273	6,254,658	30.00
31.00	03100	INTENSIVE CARE UNIT	4,511,505	2,521,990	7,033,495	-197,090	6,836,405	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,850,968	5,364,100	10,215,068	-1,977,826	8,237,242	50.00
51.00	05100	RECOVERY ROOM	533,627	94,397	628,024	-32,396	595,628	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,750,794	2,342,435	7,093,229	-465,276	6,627,953	54.00
60.00	06000	LABORATORY	2,109,876	4,351,362	6,461,238	-1,560	6,459,678	60.00
65.00	06500	RESPIRATORY THERAPY	1,898,995	493,373	2,392,368	-47,067	2,345,301	65.00
66.00	06600	PHYSICAL THERAPY	1,188,750	184,747	1,373,497	-12,311	1,361,186	66.00
67.00	06700	OCCUPATIONAL THERAPY	353,780	31,703	385,483	-3,010	382,473	67.00
68.00	06800	SPEECH PATHOLOGY	220,287	24,101	244,388	-1,200	243,188	68.00
69.00	06900	ELECTROCARDIOLOGY	750,269	577,327	1,327,596	-313,740	1,013,856	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	143	143	3,588,824	3,588,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,110,614	1,110,614	16,557	1,127,171	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,613,096	22,613,096	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	71,811	6,824	78,635	-26	78,609	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	283,543	222,282	505,825	-31,684	474,141	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	589,680	551,284	1,140,964	-100,844	1,040,120	90.01
90.02	09002	DIABETES CLINIC	39,698	32,693	72,391	0	72,391	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	123,264	71,364	194,628	-103	194,525	90.04
90.05	09005	PRIME TIME	0	3,268	3,268	0	3,268	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	3,008,089	407,840	3,415,929	-54,737	3,361,192	90.07
90.08	04950	ANDERSON WOMENS CENTER	648,897	749,163	1,398,060	-133,403	1,264,657	90.08
91.00	09100	EMERGENCY	3,314,532	1,667,665	4,982,197	-220,792	4,761,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	930,705	218,018	1,148,723	-1,148,723	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,914,942	112,326,707	168,241,649	-127,485	168,114,164	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	487,091	487,091	-19,710	467,381	190.01
190.02	19002	PHYSICIAN BUILDING	0	624,351	624,351	0	624,351	190.02
190.03	19003	PRIVATE DUTY	342,763	1,373,897	1,716,660	0	1,716,660	190.03
190.04	19004	MARKETING	0	0	0	1,099,210	1,099,210	190.04
190.05	19005	SPORTS PHYSICALS	358,719	32,689	391,408	0	391,408	190.05
190.06	19006	FOUNDATION	283,345	1,353,229	1,636,574	0	1,636,574	190.06
190.07	19007	ASC	0	12,878	12,878	-2,066	10,812	190.07
190.08	19008	GATEWAY LOCATION	3,959,651	866,003	4,825,654	-226,461	4,599,193	190.08
190.09	19009	HANCOCK OB	2,620,699	1,595,634	4,216,333	-436,164	3,780,169	190.09
190.10	19010	HANCOCK WELLNESS	922,849	286,173	1,209,022	0	1,209,022	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	1,069,446	590,150	1,659,596	0	1,659,596	190.13
190.14	19014	3 WEST UNIT	215,595	232,496	448,091	-5,137	442,954	190.14
190.15	19015	NEUROLOGY PHYSICIAN	1,224,425	430,726	1,655,151	-133,380	1,521,771	190.15

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
190.16	19016	THORACI	1,000	1,951	2,951	0	2,951	190.16
190.17	19017	HANCOCK ENDO	894,094	375,849	1,269,943	-64,686	1,205,257	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	5,788	11,564	17,352	0	17,352	190.19
194.00	07950	OTHER NONREIMBURSABLE	180	74	254	0	254	194.00
194.01	07951	SUBURBAN HOSPICE	0	0	0	259,593	259,593	194.01
194.02	07952	HRH HANCOCK GI	1,268,442	229,354	1,497,796	-5	1,497,791	194.02
194.03	07954	HRH NEPHROLOGY	102,829	82,675	185,504	0	185,504	194.03
194.04	07957	HRH SANE	148,839	39,669	188,508	-1,185	187,323	194.04
194.05	07955	HRH RISE	9,081	155,621	164,702	0	164,702	194.05
194.06	07956	HRH JUSTICE NAVIGATION	177,074	67,962	245,036	0	245,036	194.06
194.07	07953	HPN PHYSICIAN	94,262	16,650	110,912	-150	110,762	194.07
194.08	07958	HOSPITALIST	0	512,217	512,217	0	512,217	194.08
194.09	07959	HPN HANCOCK COUNSEL	62,150	5,010	67,160	0	67,160	194.09
194.10	07960	HPN HFM MCKENZIE	118,889	118,892	237,781	-106,214	131,567	194.10
194.11	07961	HPN HIM GREENFIELD	97,195	29,314	126,509	0	126,509	194.11
194.12	07962	HPN HFM BOYD	161,770	36,976	198,746	0	198,746	194.12
194.13	07963	HPN HIM MCCORD	76,143	81,912	158,055	-55,786	102,269	194.13
194.14	07964	HPN WELL BEING	45,641	28,067	73,708	-8,940	64,768	194.14
194.15	07965	PHYSICIAN BILLING SERVICE	204,054	70,356	274,410	0	274,410	194.15
194.16	07966	CLINICAL MANAGEMENT	148,119	12,078	160,197	0	160,197	194.16
194.17	07967	HANCOCK ORTHO	2,488,110	793,436	3,281,546	-61,329	3,220,217	194.17
194.18	07968	HANCOCK PEDIATRICS	95,835	37,404	133,239	-35	133,204	194.18
194.19	07969	HRN HFM NEW	144,762	127,794	272,556	-67,060	205,496	194.19
194.20	07970	HRH HFM CLEARVIEW	49,709	60,189	109,898	-43,010	66,888	194.20
200.00		TOTAL (SUM OF LINES 118 through 199)	73,306,400	123,107,038	196,413,438	0	196,413,438	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-819,395	17,161,025	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,790,864	7,190,193	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-15,561,467	22,218,271	5.00
7.00	00700	OPERATION OF PLANT	-7,261	7,609,151	7.00
9.00	00900	HOUSEKEEPING	-156,695	2,864,436	9.00
10.00	01000	DIETARY	-749,809	682,638	10.00
11.00	01100	CAFETERIA	-899,073	1,020,802	11.00
13.00	01300	NURSING ADMINISTRATION	-14,827	1,812,773	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2,591	425,465	14.00
15.00	01500	PHARMACY	-1,813,889	1,962,013	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-77,518	1,220,018	16.00
23.00	02300	PARAMED ED PRGM	-42,319	74,561	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-790,643	5,464,015	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,836,405	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-2,752,334	5,484,908	50.00
51.00	05100	RECOVERY ROOM	0	595,628	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-707,789	5,920,164	54.00
60.00	06000	LABORATORY	-723,692	5,735,986	60.00
65.00	06500	RESPIRATORY THERAPY	-2,338	2,342,963	65.00
66.00	06600	PHYSICAL THERAPY	0	1,361,186	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	382,473	67.00
68.00	06800	SPEECH PATHOLOGY	0	243,188	68.00
69.00	06900	ELECTROCARDIOLOGY	-5	1,013,851	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,588,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,127,171	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,613,096	73.00
76.00	03020	CARDIAC	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	78,609	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	-47,950	426,191	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CLINIC	-302,013	738,107	90.01
90.02	09002	DIABETES CLINIC	-26,975	45,416	90.02
90.03	09003	ASTHMA CLINIC	0	0	90.03
90.04	09004	ANDIS CLINIC	0	194,525	90.04
90.05	09005	PRIME TIME	-8,236	-4,968	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	90.06
90.07	04951	ONCOLOGY	-1,360,692	2,000,500	90.07
90.08	04950	ANDERSON WOMENS CENTER	-333,300	931,357	90.08
91.00	09100	EMERGENCY	-135,000	4,626,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-32,126,675	135,987,489	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	467,381	190.01
190.02	19002	PHYSICIAN BUILDING	0	624,351	190.02
190.03	19003	PRIVATE DUTY	0	1,716,660	190.03
190.04	19004	MARKETING	0	1,099,210	190.04
190.05	19005	SPORTS PHYSICALS	0	391,408	190.05
190.06	19006	FOUNDATION	0	1,636,574	190.06
190.07	19007	ASC	0	10,812	190.07
190.08	19008	GATEWAY LOCATION	0	4,599,193	190.08
190.09	19009	HANCOCK OB	0	3,780,169	190.09
190.10	19010	HANCOCK WELLNESS	0	1,209,022	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	190.11
190.12	19012	O3PUREMED	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	1,659,596	190.13
190.14	19014	3 WEST UNIT	0	442,954	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	1,521,771	190.15
190.16	19016	THORACI	0	2,951	190.16

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
190.17	19017	HANCOCK ENDO	0	1,205,257	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	17,352	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	254	194.00
194.01	07951	SUBURBAN HOSPICE	0	259,593	194.01
194.02	07952	HRH HANCOCK GI	0	1,497,791	194.02
194.03	07954	HRH NEPHROLOGY	0	185,504	194.03
194.04	07957	HRH SANE	0	187,323	194.04
194.05	07955	HRH RISE	0	164,702	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	245,036	194.06
194.07	07953	HPN PHYSICIAN	0	110,762	194.07
194.08	07958	HOSPITALIST	0	512,217	194.08
194.09	07959	HPN HANCOCK COUNSEL	0	67,160	194.09
194.10	07960	HPN HFM MCKENZIE	0	131,567	194.10
194.11	07961	HPN HIM GREENFIELD	0	126,509	194.11
194.12	07962	HPN HFM BOYD	0	198,746	194.12
194.13	07963	HPN HIM MCCORD	0	102,269	194.13
194.14	07964	HPN WELL BEING	0	64,768	194.14
194.15	07965	PHYSICIAN BILLING SERVICE	0	274,410	194.15
194.16	07966	CLINICAL MANAGEMENT	0	160,197	194.16
194.17	07967	HANCOCK ORTHO	0	3,220,217	194.17
194.18	07968	HANCOCK PEDIATRICS	0	133,204	194.18
194.19	07969	HRN HFM NEW	0	205,496	194.19
194.20	07970	HRH HFM CLEARVIEW	0	66,888	194.20
200.00		TOTAL (SUM OF LINES 118 through 199)	-32,126,675	164,286,763	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	1,059,492	860,383	1.00
	TOTALS		1,059,492	860,383	
	B - PLANT RECLASS				
1.00	OPERATION OF PLANT	7.00	0	2,060	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	6,693	2.00
3.00	ELECTROCARDIOLOGY	69.00	0	6,583	3.00
4.00	RESPIRATORY THERAPY	65.00	0	4,374	4.00
	TOTALS		0	19,710	
	C - MARKETING RECLASS				
1.00	MARKETING	190.04	226,588	872,622	1.00
	TOTALS		226,588	872,622	
	E - DRUG RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	22,613,096	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
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
	TOTALS		0	22,613,096	
	F - TERM ETO BENEFIT RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,577	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	89,450	2.00
3.00	OPERATION OF PLANT	7.00	0	34,071	3.00
4.00	HOUSEKEEPING	9.00	0	1,949	4.00
5.00	DIETARY	10.00	0	6,411	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	6,417	6.00
7.00	PHARMACY	15.00	0	2,836	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	23,759	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	983	9.00
10.00	OPERATING ROOM	50.00	0	6,168	10.00
11.00	RECOVERY ROOM	51.00	0	4,961	11.00
12.00	LABORATORY	60.00	0	8,672	12.00
13.00	RESPIRATORY THERAPY	65.00	0	15,792	13.00
14.00	PHYSICAL THERAPY	66.00	0	726	14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	7,227	15.00
16.00	WOUND CLINIC	90.01	0	2,520	16.00
17.00	ONCOLOGY	90.07	0	2,469	17.00
18.00	EMERGENCY	91.00	0	4,707	18.00
19.00	SUBURBAN HOSPICE	194.01	0	835	19.00
20.00	PRIVATE DUTY	190.03	0	648	20.00
21.00	GATEWAY LOCATION	190.08	0	9,456	21.00
22.00	HANCOCK OB	190.09	0	1,288	22.00

RECLASSIFICATIONS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/31/2024 7:01 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
23.00	HANCOCK WELLNESS	190.10	0	908	23.00
24.00	MCCORD WELLNESS	190.13	0	722	24.00
25.00	HRH HANCOCK GI	194.02	0	859	25.00
	TOTALS		0	242,411	
	G - TRANSITIONS UNIT RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	715,551	167,618	1.00
2.00	SUBURBAN HOSPICE	194.01	215,154	50,400	2.00
	TOTALS		930,705	218,018	
	H - IMPLANTABLE SUPPLY RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	16,557	1.00
	TOTALS		0	16,557	
	I - MED SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,588,967	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
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
	TOTALS		0	3,588,967	
500.00	Grand Total: Increases		2,216,785	28,431,764	500.00

RECLASSIFICATIONS	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet A-6 Date/Time Prepared: 5/31/2024 7:01 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA RECLASS					
1.00	DIETARY	10.00	1,059,492	860,383	0	1.00
	TOTALS		1,059,492	860,383		
	B - PLANT RECLASS					
1.00	PROFESSIONAL BUILDING	190.01	0	19,710	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		0	19,710		
	C - MARKETING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	226,588	872,622	0	1.00
	TOTALS		226,588	872,622		
	E - DRUG RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	53,354	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	166	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	27	0	3.00
4.00	PHARMACY	15.00	0	21,074,877	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	15,302	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	15,623	0	6.00
7.00	OPERATING ROOM	50.00	0	10,028	0	7.00
8.00	RECOVERY ROOM	51.00	0	1,278	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	289,613	0	9.00
10.00	LABORATORY	60.00	0	458	0	10.00
11.00	RESPIRATORY THERAPY	65.00	0	300	0	11.00
12.00	PHYSICAL THERAPY	66.00	0	1,268	0	12.00
13.00	SPEECH PATHOLOGY	68.00	0	59	0	13.00
14.00	ELECTROCARDIOLOGY	69.00	0	34,454	0	14.00
15.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	143	0	15.00
16.00	CARDIOPULMONARY	76.01	0	16	0	16.00
17.00	RURAL HEALTH CLINIC	88.00	0	31,632	0	17.00
18.00	WOUND CLINIC	90.01	0	10,211	0	18.00
19.00	ANDIS CLINIC	90.04	0	32	0	19.00
20.00	ONCOLOGY	90.07	0	13,191	0	20.00
21.00	ANDERSON WOMENS CENTER	90.08	0	774	0	21.00
22.00	SUBURBAN HOSPICE	194.01	0	773	0	22.00
24.00	GATEWAY LOCATION	190.08	0	73,287	0	24.00
25.00	HANCOCK OB	190.09	0	436,164	0	25.00
26.00	3 WEST UNIT	190.14	0	139	0	26.00
27.00	NEUROLOGY PHYSICIAN	190.15	0	126,794	0	27.00
28.00	HANCOCK ENDO	190.17	0	64,686	0	28.00
29.00	HANCOCK PEDIATRICS	194.18	0	35	0	29.00
30.00	HRN HFM NEW	194.19	0	67,060	0	30.00
31.00	HRH HFM CLEARVIEW	194.20	0	43,010	0	31.00
32.00	HRH SANE	194.04	0	1,185	0	32.00
33.00	HPN PHYSICIAN	194.07	0	150	0	33.00
34.00	HPN HFM MCKENZIE	194.10	0	106,214	0	34.00
35.00	HPN HIM MCCORD	194.13	0	55,786	0	35.00
36.00	HPN WELL BEING	194.14	0	8,940	0	36.00
37.00	HANCOCK ORTHO	194.17	0	47,830	0	37.00
38.00	EMERGENCY	91.00	0	28,237	0	38.00
	TOTALS		0	22,613,096		
	F - TERM ETO BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	8,577	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	89,450	0	0	2.00
3.00	OPERATION OF PLANT	7.00	34,071	0	0	3.00
4.00	HOUSEKEEPING	9.00	1,949	0	0	4.00
5.00	DIETARY	10.00	6,411	0	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	6,417	0	0	6.00
7.00	PHARMACY	15.00	2,836	0	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	23,759	0	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	983	0	0	9.00
10.00	OPERATING ROOM	50.00	6,168	0	0	10.00
11.00	RECOVERY ROOM	51.00	4,961	0	0	11.00
12.00	LABORATORY	60.00	8,672	0	0	12.00
13.00	RESPIRATORY THERAPY	65.00	15,792	0	0	13.00
14.00	PHYSICAL THERAPY	66.00	726	0	0	14.00
15.00	OCCUPATIONAL THERAPY	67.00	7,227	0	0	15.00
16.00	WOUND CLINIC	90.01	2,520	0	0	16.00
17.00	ONCOLOGY	90.07	2,469	0	0	17.00
18.00	EMERGENCY	91.00	4,707	0	0	18.00
19.00	SUBURBAN HOSPICE	194.01	835	0	0	19.00
20.00	PRIVATE DUTY	190.03	648	0	0	20.00
21.00	GATEWAY LOCATION	190.08	9,456	0	0	21.00

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
22.00	HANCOCK OB	190.09	1,288	0	0	22.00
23.00	HANCOCK WELLNESS	190.10	908	0	0	23.00
24.00	MCCORD WELLNESS	190.13	722	0	0	24.00
25.00	HRH HANCOCK GI	194.02	859	0	0	25.00
	TOTALS		242,411	0		
	G - TRANSITIONS UNIT RECLASS					
1.00	HOSPICE	116.00	930,705	218,018	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		930,705	218,018		
	H - IMPLANTABLE SUPPLY RECLASS					
1.00	GATEWAY LOCATION	190.08	0	16,557	0	1.00
	TOTALS		0	16,557		
	I - MED SUPPLY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,106	0	1.00
2.00	NURSING ADMINISTRATION	13.00	0	53	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,818	0	3.00
4.00	PHARMACY	15.00	0	26,589	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	223,594	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	181,467	0	6.00
7.00	OPERATING ROOM	50.00	0	1,967,798	0	7.00
8.00	RECOVERY ROOM	51.00	0	31,118	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	175,663	0	9.00
10.00	LABORATORY	60.00	0	1,102	0	10.00
11.00	RESPIRATORY THERAPY	65.00	0	51,141	0	11.00
12.00	PHYSICAL THERAPY	66.00	0	11,043	0	12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	3,010	0	13.00
14.00	SPEECH PATHOLOGY	68.00	0	1,141	0	14.00
15.00	ELECTROCARDIOLOGY	69.00	0	285,869	0	15.00
16.00	CARDIOPULMONARY	76.01	0	10	0	16.00
17.00	RURAL HEALTH CLINIC	88.00	0	52	0	17.00
18.00	WOUND CLINIC	90.01	0	90,633	0	18.00
19.00	ANDIS CLINIC	90.04	0	71	0	19.00
20.00	ONCOLOGY	90.07	0	41,546	0	20.00
21.00	ANDERSON WOMENS CENTER	90.08	0	132,629	0	21.00
22.00	EMERGENCY	91.00	0	192,555	0	22.00
24.00	ASC	190.07	0	2,066	0	24.00
25.00	GATEWAY LOCATION	190.08	0	136,617	0	25.00
26.00	3 WEST UNIT	190.14	0	4,998	0	26.00
27.00	NEUROLOGY PHYSICIAN	190.15	0	6,586	0	27.00
28.00	HRH HANCOCK GI	194.02	0	5	0	28.00
29.00	HANCOCK ORTHO	194.17	0	13,499	0	29.00
30.00	SUBURBAN HOSPICE	194.01	0	5,188	0	30.00
	TOTALS		0	3,588,967		
500.00	Grand Total: Decreases		2,459,196	28,189,353		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2024 7:01 am

		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	2,494,664	0	0	0	0	1.00
2.00	Land Improvements	26,925,681	0	0	0	0	2.00
3.00	Buildings and Fixtures	69,916,832	0	0	0	517,415	3.00
4.00	Building Improvements	108,237,385	9,139,278	0	9,139,278	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	100,005,799	6,845,172	0	6,845,172	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	307,580,361	15,984,450	0	15,984,450	517,415	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	307,580,361	15,984,450	0	15,984,450	517,415	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,494,664	0	1.00
2.00	Land Improvements	26,925,681	0	2.00
3.00	Buildings and Fixtures	69,399,417	0	3.00
4.00	Building Improvements	117,376,663	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	106,850,971	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	323,047,396	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	323,047,396	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II Date/Time Prepared: 5/31/2024 7:01 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	17,980,420	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	17,980,420	0	0	0	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	17,980,420	1.00
3.00	Total (sum of lines 1-2)	0	17,980,420	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2024 7:01 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	17,980,420	0	17,980,420	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	17,980,420	0	17,980,420	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	17,262,578	-100,209	1.00
3.00	Total (sum of lines 1-2)	0	0	0	17,262,578	-100,209	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	-1,344	0	0	0	17,161,025	1.00
3.00	Total (sum of lines 1-2)	-1,344	0	0	0	17,161,025	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 7:01 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,664,835			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	-860,383	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 7:01 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.01
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.02
33.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.03
33.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.04
33.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.05
33.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.07
33.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.08
33.09	HRH MMO RENTAL INCOME	B	-150	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.09
33.10	HRH HUMAN RESSOURCES MISC REV	B	-275,045	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	HRH OTHER ADR REV SALES TAX	B	1,540	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	HRH OTHER REVENUE MISC REV	B	-12,735	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	HRH MED STAFF SERV QA APPLICATION FE	B	-22,900	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	HRH MED STAFF SERV MISC REV	B	-2,190	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	HRH MEDICAL DUES MEDICAL STAFF DUES	B	-29,700	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	HRH PAT FIN SEV BUS SVC COPY FEES	B	-1,130	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	HRH INFO SERVICES MISC REVENUE	B	-87,475	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	HRH ACCOUINTING MISC REV	B	-112,382	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	HRH ACCOUNTING MANAGEMENT FEES		0		0.00	0	33.19
33.20	HRH EXEC ADMIN MISC REVENUE	B	-24,784	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	HRH PURCHASING MISC REV	B	-573	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	HRH COMMUINCATIONS MISC REV	B	0		0.00	0	33.22
33.23	HRH COMMUNICATIONS PHONE LEASE REV	B	-98,304	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	HRH COMM EDUCATION SERVICE REV	B	-2,805	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	HRH HEALTHY 365 MISC REV	B	-145,392	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	HRH GAIN/LOSS GROSS VARIANCE INVENTO	B	13,102	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.28	HRH CARDIO SERV MISC REV	B	-5	ELECTROCARDIOLOGY	69.00	0	33.28
33.29	HRH DIAG IMAGING MISC REV	B	-659	RADIOLOGY-DIAGNOSTIC	54.00	0	33.29
33.30	HRH PLANT OFFSITE SERV	B	-3,861	OPERATION OF PLANT	7.00	0	33.30
33.31	HRH HOUSEKEEPING ENVIRON SERVICES	B	-156,695	HOUSEKEEPING	9.00	0	33.31
33.32	HRH NUTRITIONAL SER LTACH REV	B	-122,046	DIETARY	10.00	0	33.32
33.33	HRH NUTRITIONAL SER MISC REV	B	-587	DIETARY	10.00	0	33.33
33.34	HRH NUTRITIONAL SER REBATES/REFUNDS	B	-742	DIETARY	10.00	0	33.34
33.35	HRH CLINICAL EDUCAT AHA COURSE REV	B	-14,740	NURSING ADMINISTRATION	13.00	0	33.35
33.36	HRH CLINICAL ECUATION SERVICE REV	B	0		0.00	0	33.36
33.37	HRH OTHER REVENUE REBATES/REFUNDS	B	-190	CENTRAL SERVICES & SUPPLY	14.00	0	33.37
33.38	HRH OTHER REV DISCOUNTS EARNED ON IN	B	-2,401	CENTRAL SERVICES & SUPPLY	14.00	0	33.38
33.39	HRH PHARMACY MISC REV	B	-192	PHARMACY	15.00	0	33.39

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 7:01 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.40	HRH PHARMACY REBATES/REFUNDS	B	-2,138	PHARMACY	15.00	0	33.40
33.41	HRH ASSOC PHARM RETAIL PHARM REV	B	-1,318,079	PHARMACY	15.00	0	33.41
33.42	HRH ASSOC PHARM HOSPICE PHARMACY REV	B	-227,427	PHARMACY	15.00	0	33.42
33.43	HRH ASSOC PHARM PHARMACY MED TO BED	B	-4,694	PHARMACY	15.00	0	33.43
33.44	HRH ASSOC PHARM MISC REV	B	-89,298	PHARMACY	15.00	0	33.44
33.45	HRH HEALTH INFO SER MED REC COPY FEE	B	-216	MEDICAL RECORDS & LIBRARY	16.00	0	33.45
33.46	HRH HEALTH INFO SER MISC REV	B	-77,302	MEDICAL RECORDS & LIBRARY	16.00	0	33.46
33.47	HRH XRAY SCHOOL TUITION	B	-40,335	PARAMED ED PRGM	23.00	0	33.47
33.48	HRH MED/SURG 2 EAST MISC REV	B	0		0.00	0	33.48
33.49	HRH ANDIS UNIT REBATES/REFUND	B	0		0.00	0	33.49
33.50	HRH SURGERY REBATES/REFUNDS	B	-141	OPERATING ROOM	50.00	0	33.50
33.51	HRH LAB WATER TESETING	B	-64,684	LABORATORY	60.00	0	33.51
33.52	HRH LAB DIRECT TESTS	B	-20,789	LABORATORY	60.00	0	33.52
33.53	HRH LAB MISC REV	B	-528,760	LABORATORY	60.00	0	33.53
33.54	HRH LAB WATER LAB WATER TESTING	B	0		0.00	0	33.54
33.55	HRH SLEEP STUDY CLINIC MANAGEMENT	B	-2,250	RESPIRATORY THERAPY	65.00	0	33.55
33.56	HRH SLEEP STUDY FEES	B	0	RESPIRATORY THERAPY	65.00	0	33.56
33.57	HRH CATH LAB REBATES/REFUNDS	B	0	ELECTROCARDIOLOGY	69.00	0	33.57
33.58	HRH MED ONCOLOGY MISC REV	B	-109,560	ONCOLOGY	90.07	0	33.58
33.59	HRH ER REBATES/REFUNDS	B	0	EMERGENCY	91.00	0	33.59
33.60	HRH HOSPICE MISC REV	B	-185,897	ADULTS & PEDIATRICS	30.00	0	33.60
33.61	MOW	A	-632,611	DIETARY	10.00	0	33.61
33.62	CAFETERIA GUEST MEALS	A	-38,690	CAFETERIA	11.00	0	33.62
33.63	PHYSICIAN RECRUITMENT FEES	A	-35,298	ADMINISTRATIVE & GENERAL	5.00	0	33.63
33.64	DONATIONS & SPONSORSHIPS	A	-281,316	ADMINISTRATIVE & GENERAL	5.00	0	33.64
33.65	ADVERTISING FEE	A	-69,476	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.65
33.66	ADVERTISING FEE	A	-3,674,727	ADMINISTRATIVE & GENERAL	5.00	0	33.66
33.67	ADVERTISING FEE	B	-558,985	ADMINISTRATIVE & GENERAL	5.00	0	33.67
33.68	ADVERTISING FEE	B	-1,297	ADULTS & PEDIATRICS	30.00	0	33.68
33.69	ADVERTISING FEE	B	0	OPERATING ROOM	50.00	0	33.69
33.70	ADVERTISING FEE	B	-989	RADIOLOGY-DIAGNOSTIC	54.00	0	33.70
33.71	ADVERTISING FEE	B	-1,800	RURAL HEALTH CLINIC	88.00	0	33.71
33.72	ADVERTISING FEE	A	0	SHELBYVILLE WOUND CLINIC	90.06	0	33.72
33.73	IHA LOBBYING EXPENSE	A	-4,999	ADMINISTRATIVE & GENERAL	5.00	0	33.73
33.74	AHA LOBBYING EXPENSE	A	-6,829	ADMINISTRATIVE & GENERAL	5.00	0	33.74
33.75	PHYS OFFICE BLDG DEPR EXP	A	-717,842	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.75
33.76	PHY OFFICE BLDG	A	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.76
33.77	PHY OFFICE BLDG	A	0	RURAL HEALTH CLINIC	88.00	0	33.77
33.78	INTEREST INCOME	B	-1,344	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.78
33.79	RENTAL PROPERTIES EXPENSE	A	-100,059	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.79
33.80	RENTAL PROPERTIES EXPENSE	A	-313,730	ADMINISTRATIVE & GENERAL	5.00	0	33.80
33.81	RENTAL PROPERTIES EXPENSE	A	0	OPERATION OF PLANT	7.00	0	33.81
33.82	RENTAL PROPERTIES EXPENSE	A	0	OPERATION OF PLANT	7.00	0	33.82
33.83	TELEPHONE SERVICES	A	-45,824	ADMINISTRATIVE & GENERAL	5.00	0	33.83
33.84	HAF EXPENSE	A	-9,554,026	ADMINISTRATIVE & GENERAL	5.00	0	33.84
33.85	SELF INSURANCE CLAIM EXPENSE	A	-4,446,343	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.85
33.86	HHA MISC REV	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.86
33.87	HRH NUTRITIONAL SER CAFE SALAD ROBOT	B	-742	DIETARY	10.00	0	33.87
33.88	HRH PLANT MISC REV	B	-3,400	OPERATION OF PLANT	7.00	0	33.88
33.89	HRH PAT FIN SERV EXPENSE REIMB	B	-105,165	ADMINISTRATIVE & GENERAL	5.00	0	33.89
33.90	HRH PURCHASING REBATES/REFUNDS	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.90
33.91	HRH HIFI MISC REV	B	-2,160	ADMINISTRATIVE & GENERAL	5.00	0	33.91
33.92	ADVERTISING FEE	A	0	ANDIS CLINIC	90.04	0	33.92
33.93	ADVERTISING FEE	A	0	ANDERSON WOMENS CENTER	90.08	0	33.93
33.94	ADVERTISING FEE	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.94
33.95	HRH ACCT ACCRUALS MISC REV	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.95

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/31/2024 7:01 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.96	HRH NURSING ADMIN MISC REV	B	-87	NURSING ADMINISTRATION	13.00	0	33.96
33.97	HRH PHYSICAL THER MISC REV	B	0	PHYSICAL THERAPY	66.00	0	33.97
33.98	HRH GATEWAY PROP MISC REV	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.98
33.99	HRH MCCORDSVILLE P RENTAL INC	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.99
34.00	HRH IMMED CARE RAD RENTAL INCOME	B	-8,236	PRIME TIME	90.05	0	34.00
34.01	HRH VACCINE CLINIC MANAGEMENT	B	-172,061	PHARMACY	15.00	0	34.01
34.02	HRH PAT FIN SERV MISC REV	B	-19	ADMINISTRATIVE & GENERAL	5.00	0	34.02
34.03	HRH 3N MISC REV	B	0	ADULTS & PEDIATRICS	30.00	0	34.03
34.04	HRH ANDIS UNIT MISC REV	B	0	ADULTS & PEDIATRICS	30.00	0	34.04
34.05	HRH XRAY SCHOOL STUDENT ACTIVITIES	B	468	PARAMED ED PRGM	23.00	0	34.05
34.06	HRH XRAY SCHOOL MISC REV	B	-2,452	PARAMED ED PRGM	23.00	0	34.06
34.07	HRH SLEEP STUDY MISC REV	B	-88	RESPIRATORY THERAPY	65.00	0	34.07
34.08	HRH OTHRE REVENUE FOOD & BEV TAX	B	6,919	DIETARY	10.00	0	34.08
34.09	HRH OB ANEST INCOME	B	-7,466	OPERATING ROOM	50.00	0	34.09
34.10	HRH KNIGHTSTOWN OFF MISC REV	B	-46,150	RURAL HEALTH CLINIC	88.00	0	34.10
34.11	HRH VOLUNTEERS	B	-22	ADMINISTRATIVE & GENERAL	5.00	0	34.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-32,126,675				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2024 7:01 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	452,639	452,639	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	603,449	603,449	0	211,500	0	2.00
3.00	50.00	OPERATING ROOM	2,744,727	2,744,727	0	246,400	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	706,141	706,141	0	211,500	0	4.00
5.00	60.00	LABORATORY	142,154	109,459	32,695	211,500	482	5.00
6.00	90.01	WOUND CLINIC	302,013	302,013	0	211,500	0	6.00
7.00	90.02	DIABETES CLINIC	26,975	26,975	0	211,500	0	7.00
8.00	90.04	ANDIS CLINIC	0	0	0	211,500	0	8.00
9.00	90.07	ONCOLOGY	1,251,132	1,251,132	0	211,500	0	9.00
10.00	90.08	ANDERSON WOMENS CENTER	333,300	333,300	0	211,500	0	10.00
11.00	91.00	EMERGENCY	135,000	135,000	0	211,500	0	11.00
200.00			6,697,530	6,664,835	32,695		482	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	49,011	2,451	0	0	0	5.00
6.00	90.01	WOUND CLINIC	0	0	0	0	0	6.00
7.00	90.02	DIABETES CLINIC	0	0	0	0	0	7.00
8.00	90.04	ANDIS CLINIC	0	0	0	0	0	8.00
9.00	90.07	ONCOLOGY	0	0	0	0	0	9.00
10.00	90.08	ANDERSON WOMENS CENTER	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			49,011	2,451	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	452,639	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	603,449	2.00
3.00	50.00	OPERATING ROOM	0	0	0	2,744,727	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	706,141	4.00
5.00	60.00	LABORATORY	0	49,011	0	109,459	5.00
6.00	90.01	WOUND CLINIC	0	0	0	302,013	6.00
7.00	90.02	DIABETES CLINIC	0	0	0	26,975	7.00
8.00	90.04	ANDIS CLINIC	0	0	0	0	8.00
9.00	90.07	ONCOLOGY	0	0	0	1,251,132	9.00
10.00	90.08	ANDERSON WOMENS CENTER	0	0	0	333,300	10.00
11.00	91.00	EMERGENCY	0	0	0	135,000	11.00
200.00			0	49,011	0	6,664,835	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	17,161,025	17,161,025				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,190,193	88,256	7,278,449			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,218,271	1,439,077	1,087,836	24,745,184	24,745,184	5.00
7.00	00700	OPERATION OF PLANT	7,609,151	6,663,019	120,635	14,392,805	2,552,219	7.00
9.00	00900	HOUSEKEEPING	2,864,436	36,281	201,225	3,101,942	550,055	9.00
10.00	01000	DIETARY	682,638	336,491	66,027	1,085,156	192,426	10.00
11.00	01100	CAFETERIA	1,020,802	0	106,467	1,127,269	199,894	11.00
13.00	01300	NURSING ADMINISTRATION	1,812,773	34,953	146,836	1,994,562	353,688	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	425,465	134,778	32,091	592,334	105,036	14.00
15.00	01500	PHARMACY	1,962,013	262,670	269,606	2,494,289	442,302	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,220,018	64,733	73,704	1,358,455	240,889	16.00
23.00	02300	PARAMED ED PRGM	74,561	33,170	9,856	117,587	20,851	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,464,015	1,052,674	439,915	6,956,604	1,233,587	30.00
31.00	03100	INTENSIVE CARE UNIT	6,836,405	798,112	453,258	8,087,775	1,434,173	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,484,908	459,175	486,849	6,430,932	1,140,371	50.00
51.00	05100	RECOVERY ROOM	595,628	121,426	53,125	770,179	136,573	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,920,164	894,128	477,403	7,291,695	1,293,007	54.00
60.00	06000	LABORATORY	5,735,986	189,654	211,148	6,136,788	1,088,212	60.00
65.00	06500	RESPIRATORY THERAPY	2,342,963	197,763	189,241	2,729,967	484,094	65.00
66.00	06600	PHYSICAL THERAPY	1,361,186	169,067	119,383	1,649,636	292,523	66.00
67.00	06700	OCCUPATIONAL THERAPY	382,473	0	34,825	417,298	73,998	67.00
68.00	06800	SPEECH PATHOLOGY	243,188	0	22,136	265,324	47,049	68.00
69.00	06900	ELECTROCARDIOLOGY	1,013,851	161,587	75,394	1,250,832	221,805	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,588,967	0	0	3,588,967	636,417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,127,171	0	0	1,127,171	199,877	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,613,096	0	0	22,613,096	4,009,844	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	78,609	43,586	7,216	129,411	22,948	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	426,191	0	28,493	454,684	80,627	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	738,107	117,127	59,003	914,237	162,118	90.01
90.02	09002	DIABETES CLINIC	45,416	0	3,989	49,405	8,761	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	194,525	16,707	12,387	223,619	39,653	90.04
90.05	09005	PRIME TIME	-4,968	0	0	-4,968	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	2,000,500	515,799	302,032	2,818,331	499,763	90.07
90.08	04950	ANDERSON WOMENS CENTER	931,357	143,132	65,207	1,139,696	202,098	90.08
91.00	09100	EMERGENCY	4,626,405	549,913	332,601	5,508,919	976,875	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	135,987,489	14,523,278	5,487,888	131,559,181	18,941,733	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	467,381	962,321	0	1,429,702	253,523	190.01
190.02	19002	PHYSICIAN BUILDING	624,351	0	0	624,351	110,714	190.02
190.03	19003	PRIVATE DUTY	1,716,660	15,624	34,379	1,766,663	313,275	190.03
190.04	19004	MARKETING	1,099,210	0	22,770	1,121,980	198,956	190.04
190.05	19005	SPORTS PHYSICALS	391,408	0	36,047	427,455	75,799	190.05
190.06	19006	FOUNDATION	1,636,574	56,693	28,473	1,721,740	305,309	190.06
190.07	19007	ASC	10,812	788,430	0	799,242	141,726	190.07
190.08	19008	GATEWAY LOCATION	4,599,193	0	396,951	4,996,144	885,946	190.08
190.09	19009	HANCOCK OB	3,780,169	227,927	263,222	4,271,318	757,416	190.09
190.10	19010	HANCOCK WELLNESS	1,209,022	6,641	92,645	1,308,308	231,997	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
190.13	19013	MCCORD WELLNESS	1,659,596	0	107,395	1,766,991	313,333	190.13
190.14	19014	3 WEST UNIT	442,954	432,261	21,665	896,880	159,040	190.14
190.15	19015	NEUROLOGY PHYSICIAN	1,521,771	64,523	123,041	1,709,335	303,110	190.15
190.16	19016	THORACI	2,951	0	100	3,051	541	190.16
190.17	19017	HANCOCK ENDO	1,205,257	0	89,847	1,295,104	229,656	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	17,352	0	582	17,934	3,180	190.19
194.00	07950	OTHER NONREIMBURSABLE	254	0	18	272	48	194.00
194.01	07951	SUBURBAN HOSPICE	259,593	62,810	21,537	343,940	60,990	194.01
194.02	07952	HRH HANCOCK GI	1,497,791	0	127,378	1,625,169	288,185	194.02
194.03	07954	HRH NEPHROLOGY	185,504	0	10,333	195,837	34,727	194.03
194.04	07957	HRH SANE	187,323	0	14,957	202,280	35,870	194.04
194.05	07955	HRH RISE	164,702	0	913	165,615	29,368	194.05
194.06	07956	HRH JUSTICE NAVIGATION	245,036	0	17,794	262,830	46,607	194.06
194.07	07953	HPN PHYSICIAN	110,762	0	9,472	120,234	21,321	194.07
194.08	07958	HOSPITALIST	512,217	0	0	512,217	90,829	194.08
194.09	07959	HPN HANCOCK COUNSEL	67,160	0	6,245	73,405	13,017	194.09
194.10	07960	HPN HFM MCKENZIE	131,567	0	11,947	143,514	25,449	194.10
194.11	07961	HPN HIM GREENFIELD	126,509	0	9,767	136,276	24,165	194.11
194.12	07962	HPN HFM BOYD	198,746	0	16,256	215,002	38,125	194.12
194.13	07963	HPN HIM MCCORD	102,269	0	7,652	109,921	19,492	194.13
194.14	07964	HPN WELL BEING	64,768	0	4,586	69,354	12,298	194.14
194.15	07965	PHYSICIAN BILLING SERVICE	274,410	20,517	20,505	315,432	55,934	194.15
194.16	07966	CLINICAL MANAGEMENT	160,197	0	14,884	175,081	31,046	194.16
194.17	07967	HANCOCK ORTHO	3,220,217	0	250,028	3,470,245	615,365	194.17
194.18	07968	HANCOCK PEDIATRICS	133,204	0	9,630	142,834	25,328	194.18
194.19	07969	HRN HFM NEW	205,496	0	14,547	220,043	39,019	194.19
194.20	07970	HRH HFM CLEARVIEW	66,888	0	4,995	71,883	12,747	194.20
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	164,286,763	17,161,025	7,278,449	164,286,763	24,745,184	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	16,945,024					7.00
9.00	00900	HOUSEKEEPING	76,918	3,728,915				9.00
10.00	01000	DIETARY	713,379	64,930	2,055,891			10.00
11.00	01100	CAFETERIA	0	106,995	0	1,434,158		11.00
13.00	01300	NURSING ADMINISTRATION	74,102	0	0	37,185	2,459,537	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	285,737	162,299	0	12,977	30,050	14.00
15.00	01500	PHARMACY	556,876	118,388	0	80,691	186,844	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	137,237	142,403	0	41,707	96,574	16.00
23.00	02300	PARAMED ED PRGM	70,323	164,036	0	2,895	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,231,726	1,088,313	812,730	151,129	349,947	30.00
31.00	03100	INTENSIVE CARE UNIT	1,692,042	224,371	1,201,292	159,378	369,044	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	973,476	435,643	0	108,795	251,919	50.00
51.00	05100	RECOVERY ROOM	257,430	160,414	0	14,237	32,967	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,895,600	159,471	0	145,496	336,902	54.00
60.00	06000	LABORATORY	402,077	152,177	0	96,847	224,252	60.00
65.00	06500	RESPIRATORY THERAPY	419,268	116,552	0	69,258	160,369	65.00
66.00	06600	PHYSICAL THERAPY	358,431	135,456	0	38,341	88,781	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	13,665	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7,272	0	68.00
69.00	06900	ELECTROCARDIOLOGY	342,573	264,115	0	23,189	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	92,405	0	0	3,635	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,715	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	248,315	0	0	20,647	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	1,553	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	35,421	0	0	4,395	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	1,093,521	0	0	73,883	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	303,447	233,352	0	24,128	0	90.08
91.00	09100	EMERGENCY	1,165,845	0	0	114,799	265,823	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,426,149	3,728,915	2,014,022	1,247,817	2,393,472	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	21,696	50,237	190.03
190.04	19004	MARKETING	0	0	0	5,817	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	120,193	0	0	8,590	0	190.06
190.07	19007	ASC	1,671,516	0	0	0	0	190.07
190.08	19008	GATEWAY LOCATION	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	483,218	0	0	47,860	0	190.09
190.10	19010	HANCOCK WELLNESS	14,079	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	916,418	0	0	7,057	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	136,792	0	0	8,619	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
190.17	19017	HANCOCK ENDO	0	0	0	8,654	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	11	0	194.00
194.01	07951	SUBURBAN HOSPICE	133,161	0	41,869	6,835	15,828	194.01
194.02	07952	HRH HANCOCK GI	0	0	0	6,544	0	194.02
194.03	07954	HRH NEPHROLOGY	0	0	0	208	0	194.03
194.04	07957	HRH SANE	0	0	0	803	0	194.04
194.05	07955	HRH RISE	0	0	0	1,156	0	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	0	0	7,872	0	194.06
194.07	07953	HPN PHYSICIAN	0	0	0	3,587	0	194.07
194.08	07958	HOSPITALIST	0	0	0	0	0	194.08
194.09	07959	HPN HANCOCK COUNSEL	0	0	0	3,184	0	194.09
194.10	07960	HPN HFM MCKENZIE	0	0	0	5,609	0	194.10
194.11	07961	HPN HIM GREENFIELD	0	0	0	4,655	0	194.11
194.12	07962	HPN HFM BOYD	0	0	0	8,303	0	194.12
194.13	07963	HPN HIM MCCORD	0	0	0	3,509	0	194.13
194.14	07964	HPN WELL BEING	0	0	0	0	0	194.14
194.15	07965	PHYSICIAN BILLING SERVICE	43,498	0	0	11,724	0	194.15
194.16	07966	CLINICAL MANAGEMENT	0	0	0	0	0	194.16
194.17	07967	HANCOCK ORTHO	0	0	0	0	0	194.17
194.18	07968	HANCOCK PEDIATRICS	0	0	0	4,438	0	194.18
194.19	07969	HRN HFM NEW	0	0	0	7,037	0	194.19
194.20	07970	HRH HFM CLEARVIEW	0	0	0	2,573	0	194.20
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,945,024	3,728,915	2,055,891	1,434,158	2,459,537	202.00

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,188,433					14.00
15.00	01500	PHARMACY	0	3,879,390				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2,017,265			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	375,692		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	559,296	0	13,383,332	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	69,835	0	13,237,910	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	735,111	0	10,076,247	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	1,371,800	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	83,925	375,692	11,581,788	54.00
60.00	06000	LABORATORY	0	0	186,228	0	8,286,581	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	3,979,508	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,563,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	504,961	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	319,645	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	2,102,514	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,188,433	0	95,564	0	5,509,381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,327,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,879,390	0	0	30,502,330	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	0	248,399	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	537,026	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	1,345,317	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	59,719	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	303,088	90.04
90.05	09005	PRIME TIME	0	0	0	0	-4,968	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	0	0	4,485,498	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	1,902,721	90.08
91.00	09100	EMERGENCY	0	0	287,306	0	8,319,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,188,433	3,879,390	2,017,265	375,692	121,942,580	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	1,683,225	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	735,065	190.02
190.03	19003	PRIVATE DUTY	0	0	0	0	2,151,871	190.03
190.04	19004	MARKETING	0	0	0	0	1,326,753	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	503,254	190.05
190.06	19006	FOUNDATION	0	0	0	0	2,155,832	190.06
190.07	19007	ASC	0	0	0	0	2,612,484	190.07
190.08	19008	GATEWAY LOCATION	0	0	0	0	5,882,090	190.08
190.09	19009	HANCOCK OB	0	0	0	0	5,559,812	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	1,554,384	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	2,080,324	190.13
190.14	19014	3 WEST UNIT	0	0	0	0	1,979,395	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	2,157,856	190.15
190.16	19016	THORACI	0	0	0	0	3,592	190.16

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
190.17	19017	HANCOCK ENDO	0	0	0	0	1,533,414	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	21,114	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	331	194.00
194.01	07951	SUBURBAN HOSPICE	0	0	0	0	602,623	194.01
194.02	07952	HRH HANCOCK GI	0	0	0	0	1,919,898	194.02
194.03	07954	HRH NEPHROLOGY	0	0	0	0	230,772	194.03
194.04	07957	HRH SANE	0	0	0	0	238,953	194.04
194.05	07955	HRH RISE	0	0	0	0	196,139	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	0	0	0	317,309	194.06
194.07	07953	HPN PHYSICIAN	0	0	0	0	145,142	194.07
194.08	07958	HOSPITALIST	0	0	0	0	603,046	194.08
194.09	07959	HPN HANCOCK COUNSEL	0	0	0	0	89,606	194.09
194.10	07960	HPN HFM MCKENZIE	0	0	0	0	174,572	194.10
194.11	07961	HPN HIM GREENFIELD	0	0	0	0	165,096	194.11
194.12	07962	HPN HFM BOYD	0	0	0	0	261,430	194.12
194.13	07963	HPN HIM MCCORD	0	0	0	0	132,922	194.13
194.14	07964	HPN WELL BEING	0	0	0	0	81,652	194.14
194.15	07965	PHYSICIAN BILLING SERVICE	0	0	0	0	426,588	194.15
194.16	07966	CLINICAL MANAGEMENT	0	0	0	0	206,127	194.16
194.17	07967	HANCOCK ORTHO	0	0	0	0	4,085,610	194.17
194.18	07968	HANCOCK PEDIATRICS	0	0	0	0	172,600	194.18
194.19	07969	HRN HFM NEW	0	0	0	0	266,099	194.19
194.20	07970	HRH HFM CLEARVIEW	0	0	0	0	87,203	194.20
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,188,433	3,879,390	2,017,265	375,692	164,286,763	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
23.00	02300	PARAMED ED PRGM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	13,383,332		30.00
31.00	03100	INTENSIVE CARE UNIT	0	13,237,910		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	10,076,247		50.00
51.00	05100	RECOVERY ROOM	0	1,371,800		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,581,788		54.00
60.00	06000	LABORATORY	0	8,286,581		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,979,508		65.00
66.00	06600	PHYSICAL THERAPY	0	2,563,168		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	504,961		67.00
68.00	06800	SPEECH PATHOLOGY	0	319,645		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,102,514		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,509,381		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,327,048		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	30,502,330		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	248,399		76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	537,026		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	1,345,317		90.01
90.02	09002	DIABETES CLINIC	0	59,719		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	303,088		90.04
90.05	09005	PRIME TIME	0	-4,968		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0		90.06
90.07	04951	ONCOLOGY	0	4,485,498		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	1,902,721		90.08
91.00	09100	EMERGENCY	0	8,319,567		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	121,942,580		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	1,683,225		190.01
190.02	19002	PHYSICIAN BUILDING	0	735,065		190.02
190.03	19003	PRIVATE DUTY	0	2,151,871		190.03
190.04	19004	MARKETING	0	1,326,753		190.04
190.05	19005	SPORTS PHYSICALS	0	503,254		190.05
190.06	19006	FOUNDATION	0	2,155,832		190.06
190.07	19007	ASC	0	2,612,484		190.07
190.08	19008	GATEWAY LOCATION	0	5,882,090		190.08
190.09	19009	HANCOCK OB	0	5,559,812		190.09
190.10	19010	HANCOCK WELLNESS	0	1,554,384		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	2,080,324		190.13
190.14	19014	3 WEST UNIT	0	1,979,395		190.14

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
190.15	19015	NEUROLOGY PHYSICIAN	0	2,157,856	190.15
190.16	19016	THORACI	0	3,592	190.16
190.17	19017	HANCOCK ENDO	0	1,533,414	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	21,114	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	331	194.00
194.01	07951	SUBURBAN HOSPICE	0	602,623	194.01
194.02	07952	HRH HANCOCK GI	0	1,919,898	194.02
194.03	07954	HRH NEPHROLOGY	0	230,772	194.03
194.04	07957	HRH SANE	0	238,953	194.04
194.05	07955	HRH RISE	0	196,139	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	317,309	194.06
194.07	07953	HPN PHYSICIAN	0	145,142	194.07
194.08	07958	HOSPITALIST	0	603,046	194.08
194.09	07959	HPN HANCOCK COUNSEL	0	89,606	194.09
194.10	07960	HPN HFM MCKENZIE	0	174,572	194.10
194.11	07961	HPN HIM GREENFIELD	0	165,096	194.11
194.12	07962	HPN HFM BOYD	0	261,430	194.12
194.13	07963	HPN HIM MCCORD	0	132,922	194.13
194.14	07964	HPN WELL BEING	0	81,652	194.14
194.15	07965	PHYSICIAN BILLING SERVICE	0	426,588	194.15
194.16	07966	CLINICAL MANAGEMENT	0	206,127	194.16
194.17	07967	HANCOCK ORTHO	0	4,085,610	194.17
194.18	07968	HANCOCK PEDIATRICS	0	172,600	194.18
194.19	07969	HRN HFM NEW	0	266,099	194.19
194.20	07970	HRH HFM CLEARVIEW	0	87,203	194.20
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	164,286,763	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	88,256	88,256	88,256		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,439,077	1,439,077	13,224	1,452,301	5.00
7.00	00700	OPERATION OF PLANT	0	6,663,019	6,663,019	1,462	149,786	7.00
9.00	00900	HOUSEKEEPING	0	36,281	36,281	2,439	32,282	9.00
10.00	01000	DIETARY	0	336,491	336,491	800	11,293	10.00
11.00	01100	CAFETERIA	0	0	0	1,290	11,731	11.00
13.00	01300	NURSING ADMINISTRATION	0	34,953	34,953	1,780	20,757	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	134,778	134,778	389	6,164	14.00
15.00	01500	PHARMACY	0	262,670	262,670	3,268	25,958	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	64,733	64,733	893	14,137	16.00
23.00	02300	PARAMED ED PRGM	0	33,170	33,170	119	1,224	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,052,674	1,052,674	5,332	72,397	30.00
31.00	03100	INTENSIVE CARE UNIT	0	798,112	798,112	5,494	84,169	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	459,175	459,175	5,901	66,927	50.00
51.00	05100	RECOVERY ROOM	0	121,426	121,426	644	8,015	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	894,128	894,128	5,786	75,885	54.00
60.00	06000	LABORATORY	0	189,654	189,654	2,559	63,866	60.00
65.00	06500	RESPIRATORY THERAPY	0	197,763	197,763	2,294	28,411	65.00
66.00	06600	PHYSICAL THERAPY	0	169,067	169,067	1,447	17,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	422	4,343	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	268	2,761	68.00
69.00	06900	ELECTROCARDIOLOGY	0	161,587	161,587	914	13,017	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	37,350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	11,730	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	235,375	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	43,586	43,586	87	1,347	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	345	4,732	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	117,127	117,127	715	9,514	90.01
90.02	09002	DIABETES CLINIC	0	0	0	48	514	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	16,707	16,707	150	2,327	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	515,799	515,799	3,661	29,330	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	143,132	143,132	790	11,861	90.08
91.00	09100	EMERGENCY	0	549,913	549,913	4,031	57,331	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	14,523,278	14,523,278	66,552	1,111,702	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	962,321	962,321	0	14,879	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	6,498	190.02
190.03	19003	PRIVATE DUTY	0	15,624	15,624	417	18,386	190.03
190.04	19004	MARKETING	0	0	0	276	11,676	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	437	4,449	190.05
190.06	19006	FOUNDATION	0	56,693	56,693	345	17,918	190.06
190.07	19007	ASC	0	788,430	788,430	0	8,318	190.07
190.08	19008	GATEWAY LOCATION	0	0	0	4,811	51,995	190.08
190.09	19009	HANCOCK OB	0	227,927	227,927	3,190	44,452	190.09
190.10	19010	HANCOCK WELLNESS	0	6,641	6,641	1,123	13,616	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	1,302	18,389	190.13

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
190.14	19014	3 WEST UNIT	0	432,261	432,261	263	9,334	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	64,523	64,523	1,491	17,789	190.15
190.16	19016	THORACI	0	0	0	1	32	190.16
190.17	19017	HANCOCK ENDO	0	0	0	1,089	13,478	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	7	187	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	3	194.00
194.01	07951	SUBURBAN HOSPICE	0	62,810	62,810	261	3,579	194.01
194.02	07952	HRH HANCOCK GI	0	0	0	1,544	16,913	194.02
194.03	07954	HRH NEPHROLOGY	0	0	0	125	2,038	194.03
194.04	07957	HRH SANE	0	0	0	181	2,105	194.04
194.05	07955	HRH RISE	0	0	0	11	1,724	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	0	0	216	2,735	194.06
194.07	07953	HPN PHYSICIAN	0	0	0	115	1,251	194.07
194.08	07958	HOSPITALIST	0	0	0	0	5,331	194.08
194.09	07959	HPN HANCOCK COUNSEL	0	0	0	76	764	194.09
194.10	07960	HPN HFM MCKENZIE	0	0	0	145	1,494	194.10
194.11	07961	HPN HIM GREENFIELD	0	0	0	118	1,418	194.11
194.12	07962	HPN HFM BOYD	0	0	0	197	2,238	194.12
194.13	07963	HPN HIM MCCORD	0	0	0	93	1,144	194.13
194.14	07964	HPN WELL BEING	0	0	0	56	722	194.14
194.15	07965	PHYSICIAN BILLING SERVICE	0	20,517	20,517	249	3,283	194.15
194.16	07966	CLINICAL MANAGEMENT	0	0	0	180	1,822	194.16
194.17	07967	HANCOCK ORTHO	0	0	0	3,031	36,115	194.17
194.18	07968	HANCOCK PEDIATRICS	0	0	0	117	1,486	194.18
194.19	07969	HRN HFM NEW	0	0	0	176	2,290	194.19
194.20	07970	HRH HFM CLEARVIEW	0	0	0	61	748	194.20
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	17,161,025	17,161,025	88,256	1,452,301	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	6,814,267					7.00
9.00	00900	HOUSEKEEPING	30,932	101,934				9.00
10.00	01000	DIETARY	286,878	1,775	637,237			10.00
11.00	01100	CAFETERIA	0	2,925	0	15,946		11.00
13.00	01300	NURSING ADMINISTRATION	29,799	0	0	413	87,702	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	114,906	4,437	0	144	1,072	14.00
15.00	01500	PHARMACY	223,942	3,236	0	897	6,662	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,188	3,893	0	464	3,444	16.00
23.00	02300	PARAMED ED PRGM	28,280	4,484	0	32	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	897,469	29,750	251,911	1,680	12,478	30.00
31.00	03100	INTENSIVE CARE UNIT	680,437	6,133	372,348	1,774	13,160	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	391,473	11,909	0	1,210	8,983	50.00
51.00	05100	RECOVERY ROOM	103,523	4,385	0	158	1,176	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	762,296	4,359	0	1,618	12,013	54.00
60.00	06000	LABORATORY	161,691	4,160	0	1,077	7,996	60.00
65.00	06500	RESPIRATORY THERAPY	168,604	3,186	0	770	5,718	65.00
66.00	06600	PHYSICAL THERAPY	144,139	3,703	0	426	3,166	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	152	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	81	0	68.00
69.00	06900	ELECTROCARDIOLOGY	137,762	7,220	0	258	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	37,160	0	0	40	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	19	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	99,857	0	0	230	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	17	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	14,244	0	0	49	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	439,748	0	0	822	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	122,028	6,379	0	268	0	90.08
91.00	09100	EMERGENCY	468,832	0	0	1,276	9,479	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,399,188	101,934	624,259	13,875	85,347	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	241	1,791	190.03
190.04	19004	MARKETING	0	0	0	65	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	48,334	0	0	96	0	190.06
190.07	19007	ASC	672,183	0	0	0	0	190.07
190.08	19008	GATEWAY LOCATION	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	194,321	0	0	532	0	190.09
190.10	19010	HANCOCK WELLNESS	5,662	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	368,528	0	0	78	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	55,010	0	0	96	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
190.17	19017	HANCOCK ENDO	0	0	0	96	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	SUBURBAN HOSPICE	53,549	0	12,978	76	564	194.01
194.02	07952	HRH HANCOCK GI	0	0	0	73	0	194.02
194.03	07954	HRH NEPHROLOGY	0	0	0	2	0	194.03
194.04	07957	HRH SANE	0	0	0	9	0	194.04
194.05	07955	HRH RISE	0	0	0	13	0	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	0	0	88	0	194.06
194.07	07953	HPN PHYSICIAN	0	0	0	40	0	194.07
194.08	07958	HOSPITALIST	0	0	0	0	0	194.08
194.09	07959	HPN HANCOCK COUNSEL	0	0	0	35	0	194.09
194.10	07960	HPN HFM MCKENZIE	0	0	0	62	0	194.10
194.11	07961	HPN HIM GREENFIELD	0	0	0	52	0	194.11
194.12	07962	HPN HFM BOYD	0	0	0	92	0	194.12
194.13	07963	HPN HIM MCCORD	0	0	0	39	0	194.13
194.14	07964	HPN WELL BEING	0	0	0	0	0	194.14
194.15	07965	PHYSICIAN BILLING SERVICE	17,492	0	0	130	0	194.15
194.16	07966	CLINICAL MANAGEMENT	0	0	0	0	0	194.16
194.17	07967	HANCOCK ORTHO	0	0	0	0	0	194.17
194.18	07968	HANCOCK PEDIATRICS	0	0	0	49	0	194.18
194.19	07969	HRN HFM NEW	0	0	0	78	0	194.19
194.20	07970	HRH HFM CLEARVIEW	0	0	0	29	0	194.20
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,814,267	101,934	637,237	15,946	87,702	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	261,890					14.00
15.00	01500	PHARMACY	0	526,633				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	142,752			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	67,309		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	39,579		2,363,270	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	4,942		1,966,569	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	52,020		997,598	50.00
51.00	05100	RECOVERY ROOM	0	0	0		239,327	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,939		1,762,024	54.00
60.00	06000	LABORATORY	0	0	13,178		444,181	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		406,746	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		339,116	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		4,917	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		3,110	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		320,758	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	261,890	0	6,763		306,003	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		11,730	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	526,633	0		762,008	73.00
76.00	03020	CARDIAC	0	0	0		0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0		82,220	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0		0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0		0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0		5,096	88.00
90.00	09000	CLINIC	0	0	0		0	90.00
90.01	09001	WOUND CLINIC	0	0	0		227,443	90.01
90.02	09002	DIABETES CLINIC	0	0	0		579	90.02
90.03	09003	ASTHMA CLINIC	0	0	0		0	90.03
90.04	09004	ANDIS CLINIC	0	0	0		33,477	90.04
90.05	09005	PRIME TIME	0	0	0		0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		0	90.06
90.07	04951	ONCOLOGY	0	0	0		989,360	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0		284,458	90.08
91.00	09100	EMERGENCY	0	0	20,331		1,111,193	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0		0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	261,890	526,633	142,752	0	12,661,183	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		977,200	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		6,498	190.02
190.03	19003	PRIVATE DUTY	0	0	0		36,459	190.03
190.04	19004	MARKETING	0	0	0		12,017	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		4,886	190.05
190.06	19006	FOUNDATION	0	0	0		123,386	190.06
190.07	19007	ASC	0	0	0		1,468,931	190.07
190.08	19008	GATEWAY LOCATION	0	0	0		56,806	190.08
190.09	19009	HANCOCK OB	0	0	0		470,422	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		27,042	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		0	190.11
190.12	19012	O3PUREMED	0	0	0		0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0		19,691	190.13
190.14	19014	3 WEST UNIT	0	0	0		810,464	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		138,909	190.15
190.16	19016	THORACI	0	0	0		33	190.16

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
190.17	19017	HANCOCK ENDO	0	0	0		14,663	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0		0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0		194	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0		3	194.00
194.01	07951	SUBURBAN HOSPICE	0	0	0		133,817	194.01
194.02	07952	HRH HANCOCK GI	0	0	0		18,530	194.02
194.03	07954	HRH NEPHROLOGY	0	0	0		2,165	194.03
194.04	07957	HRH SANE	0	0	0		2,295	194.04
194.05	07955	HRH RISE	0	0	0		1,748	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	0	0		3,039	194.06
194.07	07953	HPN PHYSICIAN	0	0	0		1,406	194.07
194.08	07958	HOSPITALIST	0	0	0		5,331	194.08
194.09	07959	HPN HANCOCK COUNSEL	0	0	0		875	194.09
194.10	07960	HPN HFM MCKENZIE	0	0	0		1,701	194.10
194.11	07961	HPN HIM GREENFIELD	0	0	0		1,588	194.11
194.12	07962	HPN HFM BOYD	0	0	0		2,527	194.12
194.13	07963	HPN HIM MCCORD	0	0	0		1,276	194.13
194.14	07964	HPN WELL BEING	0	0	0		778	194.14
194.15	07965	PHYSICIAN BILLING SERVICE	0	0	0		41,671	194.15
194.16	07966	CLINICAL MANAGEMENT	0	0	0		2,002	194.16
194.17	07967	HANCOCK ORTHO	0	0	0		39,146	194.17
194.18	07968	HANCOCK PEDIATRICS	0	0	0		1,652	194.18
194.19	07969	HRN HFM NEW	0	0	0		2,544	194.19
194.20	07970	HRH HFM CLEARVIEW	0	0	0		838	194.20
200.00		Cross Foot Adjustments				67,309	67,309	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	261,890	526,633	142,752	67,309	17,161,025	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
23.00	02300	PARAMED ED PRGM			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	2,363,270	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,966,569	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	997,598	50.00
51.00	05100	RECOVERY ROOM	0	239,327	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,762,024	54.00
60.00	06000	LABORATORY	0	444,181	60.00
65.00	06500	RESPIRATORY THERAPY	0	406,746	65.00
66.00	06600	PHYSICAL THERAPY	0	339,116	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,917	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,110	68.00
69.00	06900	ELECTROCARDIOLOGY	0	320,758	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	306,003	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	11,730	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	762,008	73.00
76.00	03020	CARDIAC	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	82,220	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	5,096	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CLINIC	0	227,443	90.01
90.02	09002	DIABETES CLINIC	0	579	90.02
90.03	09003	ASTHMA CLINIC	0	0	90.03
90.04	09004	ANDIS CLINIC	0	33,477	90.04
90.05	09005	PRIME TIME	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	90.06
90.07	04951	ONCOLOGY	0	989,360	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	284,458	90.08
91.00	09100	EMERGENCY	0	1,111,193	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	12,661,183	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	977,200	190.01
190.02	19002	PHYSICIAN BUILDING	0	6,498	190.02
190.03	19003	PRIVATE DUTY	0	36,459	190.03
190.04	19004	MARKETING	0	12,017	190.04
190.05	19005	SPORTS PHYSICALS	0	4,886	190.05
190.06	19006	FOUNDATION	0	123,386	190.06
190.07	19007	ASC	0	1,468,931	190.07
190.08	19008	GATEWAY LOCATION	0	56,806	190.08
190.09	19009	HANCOCK OB	0	470,422	190.09
190.10	19010	HANCOCK WELLNESS	0	27,042	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	190.11
190.12	19012	O3PUREMED	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	19,691	190.13
190.14	19014	3 WEST UNIT	0	810,464	190.14

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
190.15	19015	NEUROLOGY PHYSICIAN	0	138,909	190.15
190.16	19016	THORACI	0	33	190.16
190.17	19017	HANCOCK ENDO	0	14,663	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	194	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	3	194.00
194.01	07951	SUBURBAN HOSPICE	0	133,817	194.01
194.02	07952	HRH HANCOCK GI	0	18,530	194.02
194.03	07954	HRH NEPHROLOGY	0	2,165	194.03
194.04	07957	HRH SANE	0	2,295	194.04
194.05	07955	HRH RISE	0	1,748	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	3,039	194.06
194.07	07953	HPN PHYSICIAN	0	1,406	194.07
194.08	07958	HOSPITALIST	0	5,331	194.08
194.09	07959	HPN HANCOCK COUNSEL	0	875	194.09
194.10	07960	HPN HFM MCKENZIE	0	1,701	194.10
194.11	07961	HPN HIM GREENFIELD	0	1,588	194.11
194.12	07962	HPN HFM BOYD	0	2,527	194.12
194.13	07963	HPN HIM MCCORD	0	1,276	194.13
194.14	07964	HPN WELL BEING	0	778	194.14
194.15	07965	PHYSICIAN BILLING SERVICE	0	41,671	194.15
194.16	07966	CLINICAL MANAGEMENT	0	2,002	194.16
194.17	07967	HANCOCK ORTHO	0	39,146	194.17
194.18	07968	HANCOCK PEDIATRICS	0	1,652	194.18
194.19	07969	HRN HFM NEW	0	2,544	194.19
194.20	07970	HRH HFM CLEARVIEW	0	838	194.20
200.00		Cross Foot Adjustments	0	67,309	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	17,161,025	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	490,977					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,525	72,430,278				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	41,172	10,825,390	-24,745,184	139,546,547		5.00
7.00	00700	OPERATION OF PLANT	190,629	1,200,480	0	14,392,805	228,672	7.00
9.00	00900	HOUSEKEEPING	1,038	2,002,456	0	3,101,942	1,038	9.00
10.00	01000	DIETARY	9,627	657,053	0	1,085,156	9,627	10.00
11.00	01100	CAFETERIA	0	1,059,492	0	1,127,269	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,000	1,461,219	0	1,994,562	1,000	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,856	319,344	0	592,334	3,856	14.00
15.00	01500	PHARMACY	7,515	2,682,936	0	2,494,289	7,515	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,852	733,457	0	1,358,455	1,852	16.00
23.00	02300	PARAMED ED PRGM	949	98,083	0	117,587	949	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,117	4,377,744	0	6,956,604	30,117	30.00
31.00	03100	INTENSIVE CARE UNIT	22,834	4,510,522	0	8,087,775	22,834	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,137	4,844,800	0	6,430,932	13,137	50.00
51.00	05100	RECOVERY ROOM	3,474	528,666	0	770,179	3,474	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,581	4,750,794	0	7,291,695	25,581	54.00
60.00	06000	LABORATORY	5,426	2,101,204	0	6,136,788	5,426	60.00
65.00	06500	RESPIRATORY THERAPY	5,658	1,883,203	0	2,729,967	5,658	65.00
66.00	06600	PHYSICAL THERAPY	4,837	1,188,024	0	1,649,636	4,837	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	346,553	0	417,298	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	220,287	0	265,324	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,623	750,269	0	1,250,832	4,623	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,588,967	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,127,171	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,613,096	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	1,247	71,811	0	129,411	1,247	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	283,543	0	454,684	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	3,351	587,160	0	914,237	3,351	90.01
90.02	09002	DIABETES CLINIC	0	39,698	0	49,405	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	478	123,264	0	223,619	478	90.04
90.05	09005	PRIME TIME	0	0	4,968	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	14,757	3,005,620	0	2,818,331	14,757	90.07
90.08	04950	ANDERSON WOMENS CENTER	4,095	648,897	0	1,139,696	4,095	90.08
91.00	09100	EMERGENCY	15,733	3,309,825	0	5,508,919	15,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	415,511	54,611,794	-24,740,216	106,818,965	181,185	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	27,532	0	0	1,429,702	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	624,351	0	190.02
190.03	19003	PRIVATE DUTY	447	342,115	0	1,766,663	0	190.03
190.04	19004	MARKETING	0	226,588	0	1,121,980	0	190.04
190.05	19005	SPORTS PHYSICALS	0	358,719	0	427,455	0	190.05
190.06	19006	FOUNDATION	1,622	283,345	0	1,721,740	1,622	190.06
190.07	19007	ASC	22,557	0	0	799,242	22,557	190.07
190.08	19008	GATEWAY LOCATION	0	3,950,195	0	4,996,144	0	190.08
190.09	19009	HANCOCK OB	6,521	2,619,411	0	4,271,318	6,521	190.09
190.10	19010	HANCOCK WELLNESS	190	921,941	0	1,308,308	190	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
190.13	19013	MCCORD WELLNESS	0	1,068,724	0	1,766,991	0	190.13
190.14	19014	3 WEST UNIT	12,367	215,595	0	896,880	12,367	190.14
190.15	19015	NEUROLOGY PHYSICIAN	1,846	1,224,425	0	1,709,335	1,846	190.15
190.16	19016	THORACI	0	1,000	0	3,051	0	190.16
190.17	19017	HANCOCK ENDO	0	894,094	0	1,295,104	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	5,788	0	17,934	0	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	180	0	272	0	194.00
194.01	07951	SUBURBAN HOSPICE	1,797	214,319	0	343,940	1,797	194.01
194.02	07952	HRH HANCOCK GI	0	1,267,583	0	1,625,169	0	194.02
194.03	07954	HRH NEPHROLOGY	0	102,829	0	195,837	0	194.03
194.04	07957	HRH SANE	0	148,839	0	202,280	0	194.04
194.05	07955	HRH RISE	0	9,081	0	165,615	0	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	177,074	0	262,830	0	194.06
194.07	07953	HPN PHYSICIAN	0	94,262	0	120,234	0	194.07
194.08	07958	HOSPITALIST	0	0	0	512,217	0	194.08
194.09	07959	HPN HANCOCK COUNSEL	0	62,150	0	73,405	0	194.09
194.10	07960	HPN HFM MCKENZIE	0	118,889	0	143,514	0	194.10
194.11	07961	HPN HIM GREENFIELD	0	97,195	0	136,276	0	194.11
194.12	07962	HPN HFM BOYD	0	161,770	0	215,002	0	194.12
194.13	07963	HPN HIM MCCORD	0	76,143	0	109,921	0	194.13
194.14	07964	HPN WELL BEING	0	45,641	0	69,354	0	194.14
194.15	07965	PHYSICIAN BILLING SERVICE	587	204,054	0	315,432	587	194.15
194.16	07966	CLINICAL MANAGEMENT	0	148,119	0	175,081	0	194.16
194.17	07967	HANCOCK ORTHO	0	2,488,110	0	3,470,245	0	194.17
194.18	07968	HANCOCK PEDIATRICS	0	95,835	0	142,834	0	194.18
194.19	07969	HRN HFM NEW	0	144,762	0	220,043	0	194.19
194.20	07970	HRH HFM CLEARVIEW	0	49,709	0	71,883	0	194.20
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)	17,161,025	7,278,449		24,745,184	16,945,024	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.952808	0.100489		0.177326	74.101875	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		88,256		1,452,301	6,814,267	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001218		0.010407	29.799306	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING	375,765					9.00
10.00	01000	DIETARY	6,543	10,508				10.00
11.00	01100	CAFETERIA	10,782	0	939,129			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	24,350	695,551		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,355	0	8,498	8,498	100	14.00
15.00	01500	PHARMACY	11,930	0	52,839	52,839	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,350	0	27,311	27,311	0	16.00
23.00	02300	PARAMED ED PRGM	16,530	0	1,896	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,670	4,154	98,964	98,964	0	30.00
31.00	03100	INTENSIVE CARE UNIT	22,610	6,140	104,365	104,365	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,900	0	71,242	71,242	0	50.00
51.00	05100	RECOVERY ROOM	16,165	0	9,323	9,323	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,070	0	95,275	95,275	0	54.00
60.00	06000	LABORATORY	15,335	0	63,418	63,418	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,745	0	45,352	45,352	0	65.00
66.00	06600	PHYSICAL THERAPY	13,650	0	25,107	25,107	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	8,948	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	4,762	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26,615	0	15,185	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	2,380	0	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,123	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	13,520	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	1,017	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	2,878	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	48,381	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	23,515	0	15,800	0	0	90.08
91.00	09100	EMERGENCY	0	0	75,174	75,174	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	375,765	10,294	817,108	676,868	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	14,207	14,207	0	190.03
190.04	19004	MARKETING	0	0	3,809	0	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	5,625	0	0	190.06
190.07	19007	ASC	0	0	0	0	0	190.07
190.08	19008	GATEWAY LOCATION	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	0	0	31,340	0	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	0	0	4,621	0	0	190.14

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
190.15	19015	NEUROLOGY PHYSICIAN	0	0	5,644	0	0	190.15
190.16	19016	THORACI	0	0	0	0	0	190.16
190.17	19017	HANCOCK ENDO	0	0	5,667	0	0	190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0	0	0	190.18
190.19	19019	HANCOCK RHEUM	0	0	0	0	0	190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	7	0	0	194.00
194.01	07951	SUBURBAN HOSPICE	0	214	4,476	4,476	0	194.01
194.02	07952	HRH HANCOCK GI	0	0	4,285	0	0	194.02
194.03	07954	HRH NEPHROLOGY	0	0	136	0	0	194.03
194.04	07957	HRH SANE	0	0	526	0	0	194.04
194.05	07955	HRH RISE	0	0	757	0	0	194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	0	5,155	0	0	194.06
194.07	07953	HPN PHYSICIAN	0	0	2,349	0	0	194.07
194.08	07958	HOSPITALIST	0	0	0	0	0	194.08
194.09	07959	HPN HANCOCK COUNSEL	0	0	2,085	0	0	194.09
194.10	07960	HPN HFM MCKENZIE	0	0	3,673	0	0	194.10
194.11	07961	HPN HIM GREENFIELD	0	0	3,048	0	0	194.11
194.12	07962	HPN HFM BOYD	0	0	5,437	0	0	194.12
194.13	07963	HPN HIM MCCORD	0	0	2,298	0	0	194.13
194.14	07964	HPN WELL BEING	0	0	0	0	0	194.14
194.15	07965	PHYSICIAN BILLING SERVICE	0	0	7,677	0	0	194.15
194.16	07966	CLINICAL MANAGEMENT	0	0	0	0	0	194.16
194.17	07967	HANCOCK ORTHO	0	0	0	0	0	194.17
194.18	07968	HANCOCK PEDIATRICS	0	0	2,906	0	0	194.18
194.19	07969	HRN HFM NEW	0	0	4,608	0	0	194.19
194.20	07970	HRH HFM CLEARVIEW	0	0	1,685	0	0	194.20
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,728,915	2,055,891	1,434,158	2,459,537	1,188,433	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.923529	195.650076	1.527115	3.536099	11,884.330000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	101,934	637,237	15,946	87,702	261,890	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.271271	60.643034	0.016980	0.126090	2,618.900000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,293			16.00
23.00	02300	PARAMED ED PRGM	0	0	100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	913	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	114	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,200	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	137	100		54.00
60.00	06000	LABORATORY	0	304	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	156	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	0	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0	0		76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINIC	0	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0	0		90.04
90.05	09005	PRIME TIME	0	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		90.06
90.07	04951	ONCOLOGY	0	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0		90.08
91.00	09100	EMERGENCY	0	469	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	3,293	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		190.02
190.03	19003	PRIVATE DUTY	0	0	0		190.03
190.04	19004	MARKETING	0	0	0		190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		190.05
190.06	19006	FOUNDATION	0	0	0		190.06
190.07	19007	ASC	0	0	0		190.07
190.08	19008	GATEWAY LOCATION	0	0	0		190.08
190.09	19009	HANCOCK OB	0	0	0		190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		190.11
190.12	19012	O3PUREMED	0	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	0	0		190.13
190.14	19014	3 WEST UNIT	0	0	0		190.14

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/31/2024 7:01 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		190.15
190.16	19016	THORACI	0	0	0		190.16
190.17	19017	HANCOCK ENDO	0	0	0		190.17
190.18	19018	HANCOCK FOOT & ANKLE	0	0	0		190.18
190.19	19019	HANCOCK RHEUM	0	0	0		190.19
194.00	07950	OTHER NONREIMBURSABLE	0	0	0		194.00
194.01	07951	SUBURBAN HOSPICE	0	0	0		194.01
194.02	07952	HRH HANCOCK GI	0	0	0		194.02
194.03	07954	HRH NEPHROLOGY	0	0	0		194.03
194.04	07957	HRH SANE	0	0	0		194.04
194.05	07955	HRH RISE	0	0	0		194.05
194.06	07956	HRH JUSTICE NAVIGATION	0	0	0		194.06
194.07	07953	HPN PHYSICIAN	0	0	0		194.07
194.08	07958	HOSPITALIST	0	0	0		194.08
194.09	07959	HPN HANCOCK COUNSEL	0	0	0		194.09
194.10	07960	HPN HFM MCKENZIE	0	0	0		194.10
194.11	07961	HPN HIM GREENFIELD	0	0	0		194.11
194.12	07962	HPN HFM BOYD	0	0	0		194.12
194.13	07963	HPN HIM MCCORD	0	0	0		194.13
194.14	07964	HPN WELL BEING	0	0	0		194.14
194.15	07965	PHYSICIAN BILLING SERVICE	0	0	0		194.15
194.16	07966	CLINICAL MANAGEMENT	0	0	0		194.16
194.17	07967	HANCOCK ORTHO	0	0	0		194.17
194.18	07968	HANCOCK PEDIATRICS	0	0	0		194.18
194.19	07969	HRN HFM NEW	0	0	0		194.19
194.20	07970	HRH HFM CLEARVIEW	0	0	0		194.20
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,879,390	2,017,265	375,692		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38,793.900000	612.591862	3,756.920000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	526,633	142,752	67,309		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5,266.330000	43.350137	673.090000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 7:01 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,383,332		13,383,332	0	13,383,332	30.00
31.00	03100	INTENSIVE CARE UNIT	13,237,910		13,237,910	0	13,237,910	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,076,247		10,076,247	0	10,076,247	50.00
51.00	05100	RECOVERY ROOM	1,371,800		1,371,800	0	1,371,800	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,581,788		11,581,788	0	11,581,788	54.00
60.00	06000	LABORATORY	8,286,581		8,286,581	0	8,286,581	60.00
65.00	06500	RESPIRATORY THERAPY	3,979,508	0	3,979,508	0	3,979,508	65.00
66.00	06600	PHYSICAL THERAPY	2,563,168	0	2,563,168	0	2,563,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	504,961	0	504,961	0	504,961	67.00
68.00	06800	SPEECH PATHOLOGY	319,645	0	319,645	0	319,645	68.00
69.00	06900	ELECTROCARDIOLOGY	2,102,514		2,102,514	0	2,102,514	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,509,381		5,509,381	0	5,509,381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,327,048		1,327,048	0	1,327,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,502,330		30,502,330	0	30,502,330	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	248,399		248,399	0	248,399	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	537,026		537,026	0	537,026	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,345,317		1,345,317	0	1,345,317	90.01
90.02	09002	DIABETES CLINIC	59,719		59,719	0	59,719	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	303,088		303,088	0	303,088	90.04
90.05	09005	PRIME TIME	0		0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0		0	0	0	90.06
90.07	04951	ONCOLOGY	4,485,498		4,485,498	0	4,485,498	90.07
90.08	04950	ANDERSON WOMENS CENTER	1,902,721		1,902,721	0	1,902,721	90.08
91.00	09100	EMERGENCY	8,319,567		8,319,567	0	8,319,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,650,832		5,650,832		5,650,832	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	127,598,380	0	127,598,380	0	127,598,380	200.00
201.00		Less Observation Beds	5,650,832		5,650,832		5,650,832	201.00
202.00		Total (see instructions)	121,947,548	0	121,947,548	0	121,947,548	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/31/2024 7:01 am

Title XVIII | Hospital | PPS

		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	10,913,945		10,913,945			30.00
31.00	03100	INTENSIVE CARE UNIT	15,418,087		15,418,087			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,557,227	37,883,957	47,441,184	0.212395	0.000000	50.00
51.00	05100	RECOVERY ROOM	904,624	2,316,081	3,220,705	0.425932	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,107,776	98,580,189	102,687,965	0.112786	0.000000	54.00
60.00	06000	LABORATORY	8,540,959	56,167,236	64,708,195	0.128061	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,234,949	8,584,240	10,819,189	0.367819	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	573,634	4,859,989	5,433,623	0.471724	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	471,110	882,253	1,353,363	0.373116	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	240,205	792,904	1,033,109	0.309401	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,398,217	13,877,995	17,276,212	0.121700	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	428,553	1,136,209	1,564,762	3.520907	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,440,224	8,982,603	10,422,827	0.127321	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,910,224	121,367,759	131,277,983	0.232349	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	486,642	486,642	0.510435	0.000000	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	853,313	853,313			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	9,400	5,827,910	5,837,310	0.230469	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	5,441	5,441	10.975740	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	48,801	48,801	6.210692	0.000000	90.04
90.05	09005	PRIME TIME	0	0	0	0.000000	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0.000000	0.000000	90.06
90.07	04951	ONCOLOGY	19,798	8,405,777	8,425,575	0.532367	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	5,206,148	5,206,148	0.365476	0.000000	90.08
91.00	09100	EMERGENCY	8,549,181	71,411,281	79,960,462	0.104046	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	438,106	17,396,387	17,834,493	0.316848	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	77,156,219	465,073,115	542,229,334			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	77,156,219	465,073,115	542,229,334			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/31/2024 7:01 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.212395	50.00
51.00	05100	RECOVERY ROOM	0.425932	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.112786	54.00
60.00	06000	LABORATORY	0.128061	60.00
65.00	06500	RESPIRATORY THERAPY	0.367819	65.00
66.00	06600	PHYSICAL THERAPY	0.471724	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373116	67.00
68.00	06800	SPEECH PATHOLOGY	0.309401	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121700	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3.520907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.127321	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.232349	73.00
76.00	03020	CARDIAC	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0.510435	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINIC	0.230469	90.01
90.02	09002	DIABETES CLINIC	10.975740	90.02
90.03	09003	ASTHMA CLINIC	0.000000	90.03
90.04	09004	ANDIS CLINIC	6.210692	90.04
90.05	09005	PRIME TIME	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	90.06
90.07	04951	ONCOLOGY	0.532367	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.365476	90.08
91.00	09100	EMERGENCY	0.104046	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.316848	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/31/2024 7:01 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,383,332		13,383,332	0	13,383,332	30.00
31.00	03100	INTENSIVE CARE UNIT	13,237,910		13,237,910	0	13,237,910	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,076,247		10,076,247	0	10,076,247	50.00
51.00	05100	RECOVERY ROOM	1,371,800		1,371,800	0	1,371,800	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,581,788		11,581,788	0	11,581,788	54.00
60.00	06000	LABORATORY	8,286,581		8,286,581	0	8,286,581	60.00
65.00	06500	RESPIRATORY THERAPY	3,979,508	0	3,979,508	0	3,979,508	65.00
66.00	06600	PHYSICAL THERAPY	2,563,168	0	2,563,168	0	2,563,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	504,961	0	504,961	0	504,961	67.00
68.00	06800	SPEECH PATHOLOGY	319,645	0	319,645	0	319,645	68.00
69.00	06900	ELECTROCARDIOLOGY	2,102,514		2,102,514	0	2,102,514	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,509,381		5,509,381	0	5,509,381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,327,048		1,327,048	0	1,327,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,502,330		30,502,330	0	30,502,330	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	248,399		248,399	0	248,399	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	537,026		537,026	0	537,026	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,345,317		1,345,317	0	1,345,317	90.01
90.02	09002	DIABETES CLINIC	59,719		59,719	0	59,719	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	303,088		303,088	0	303,088	90.04
90.05	09005	PRIME TIME	0		0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0		0	0	0	90.06
90.07	04951	ONCOLOGY	4,485,498		4,485,498	0	4,485,498	90.07
90.08	04950	ANDERSON WOMENS CENTER	1,902,721		1,902,721	0	1,902,721	90.08
91.00	09100	EMERGENCY	8,319,567		8,319,567	0	8,319,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,650,832		5,650,832		5,650,832	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	127,598,380	0	127,598,380	0	127,598,380	200.00
201.00		Less Observation Beds	5,650,832		5,650,832		5,650,832	201.00
202.00		Total (see instructions)	121,947,548	0	121,947,548	0	121,947,548	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/31/2024 7:01 am

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	10,913,945		10,913,945			30.00
31.00	03100	INTENSIVE CARE UNIT	15,418,087		15,418,087			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,557,227	37,883,957	47,441,184	0.212395	0.000000	50.00
51.00	05100	RECOVERY ROOM	904,624	2,316,081	3,220,705	0.425932	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,107,776	98,580,189	102,687,965	0.112786	0.000000	54.00
60.00	06000	LABORATORY	8,540,959	56,167,236	64,708,195	0.128061	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,234,949	8,584,240	10,819,189	0.367819	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	573,634	4,859,989	5,433,623	0.471724	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	471,110	882,253	1,353,363	0.373116	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	240,205	792,904	1,033,109	0.309401	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,398,217	13,877,995	17,276,212	0.121700	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	428,553	1,136,209	1,564,762	3.520907	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,440,224	8,982,603	10,422,827	0.127321	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,910,224	121,367,759	131,277,983	0.232349	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	486,642	486,642	0.510435	0.000000	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	853,313	853,313	0.629342	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	9,400	5,827,910	5,837,310	0.230469	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	5,441	5,441	10.975740	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	48,801	48,801	6.210692	0.000000	90.04
90.05	09005	PRIME TIME	0	0	0	0.000000	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0.000000	0.000000	90.06
90.07	04951	ONCOLOGY	19,798	8,405,777	8,425,575	0.532367	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	5,206,148	5,206,148	0.365476	0.000000	90.08
91.00	09100	EMERGENCY	8,549,181	71,411,281	79,960,462	0.104046	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	438,106	17,396,387	17,834,493	0.316848	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	77,156,219	465,073,115	542,229,334			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	77,156,219	465,073,115	542,229,334			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I | Date/Time Prepared: 5/31/2024 7:01 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	CARDIAC	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0.000000	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINIC	0.000000	90.01
90.02	09002	DIABETES CLINIC	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0.000000	90.03
90.04	09004	ANDIS CLINIC	0.000000	90.04
90.05	09005	PRIME TIME	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	90.06
90.07	04951	ONCOLOGY	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000	90.08
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I | Date/Time Prepared: 5/31/2024 7:01 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,363,270	0	2,363,270	8,673	272.49	30.00
31.00	INTENSIVE CARE UNIT	1,966,569		1,966,569	6,140	320.29	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
200.00	Total (lines 30 through 199)	4,329,839		4,329,839	14,813		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	935	254,778	30.00
31.00	INTENSIVE CARE UNIT	1,858	595,099	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
200.00	Total (lines 30 through 199)	2,793	849,877	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/31/2024 7:01 am

Title XVIII | Hospital | PPS

		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	997,598	47,441,184	0.021028	2,490,478	52,370	50.00
51.00	05100	RECOVERY ROOM	239,327	3,220,705	0.074309	207,889	15,448	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,762,024	102,687,965	0.017159	3,096,219	53,128	54.00
60.00	06000	LABORATORY	444,181	64,708,195	0.006864	4,401,330	30,211	60.00
65.00	06500	RESPIRATORY THERAPY	406,746	10,819,189	0.037595	789,309	29,674	65.00
66.00	06600	PHYSICAL THERAPY	339,116	5,433,623	0.062411	219,623	13,707	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,917	1,353,363	0.003633	174,241	633	67.00
68.00	06800	SPEECH PATHOLOGY	3,110	1,033,109	0.003010	83,245	251	68.00
69.00	06900	ELECTROCARDIOLOGY	320,758	17,276,212	0.018566	1,506,407	27,968	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	306,003	1,564,762	0.195559	153,377	29,994	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,730	10,422,827	0.001125	695,522	782	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	762,008	131,277,983	0.005805	3,876,940	22,506	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	82,220	486,642	0.168954	0	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,096	853,313	0.005972	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	227,443	5,837,310	0.038964	0	0	90.01
90.02	09002	DIABETES CLINIC	579	5,441	0.106414	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	33,477	48,801	0.685990	0	0	90.04
90.05	09005	PRIME TIME	0	0	0.000000	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0.000000	0	0	90.06
90.07	04951	ONCOLOGY	989,360	8,425,575	0.117423	19,798	2,325	90.07
90.08	04950	ANDERSON WOMENS CENTER	284,458	5,206,148	0.054639	0	0	90.08
91.00	09100	EMERGENCY	1,111,193	79,960,462	0.013897	3,961,191	55,049	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	997,841	17,834,493	0.055950	438,106	24,512	92.00
200.00		Total (lines 50 through 199)	9,329,185	515,897,302		22,113,675	358,558	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III | Date/Time Prepared: 5/31/2024 7:01 am

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	8,673	0.00	935	30.00
31.00	03100	INTENSIVE CARE UNIT		0	6,140	0.00	1,858	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
200.00		Total (lines 30 through 199)		0	14,813		2,793	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/31/2024 7:01 am
	Title XVIII	Hospital	PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	375,692	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	0	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	375,692	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/31/2024 7:01 am

Title XVIII | Hospital | PPS

		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	47,441,184	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,220,705	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	375,692	375,692	102,687,965	0.003659	54.00
60.00	06000	LABORATORY	0	0	0	64,708,195	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,819,189	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,433,623	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,353,363	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,033,109	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,276,212	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,564,762	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	10,422,827	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	131,277,983	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	0	0	486,642	0.000000	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	853,313	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	0	0	5,837,310	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	0	0	5,441	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	0	0	48,801	0.000000	90.04
90.05	09005	PRIME TIME	0	0	0	0	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0.000000	90.06
90.07	04951	ONCOLOGY	0	0	0	8,425,575	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	5,206,148	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	79,960,462	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	17,834,493	0.000000	92.00
200.00		Total (lines 50 through 199)	0	375,692	375,692	515,897,302		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/31/2024 7:01 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,490,478	0	6,801,082	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	207,889	0	316,386	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.003659	3,096,219	11,329	23,598,387	86,346	54.00
60.00	06000	LABORATORY	0.000000	4,401,330	0	5,443,081	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	789,309	0	1,507,466	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	219,623	0	23,201	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	174,241	0	8,764	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	83,245	0	4,896	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,506,407	0	3,467,552	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	153,377	0	265,052	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	695,522	0	1,959,811	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,876,940	0	38,733,869	0	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.000000	0	0	186,803	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.000000	0	0	399,040	0	90.01
90.02	09002	DIABETES CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0.000000	19,798	0	2,482,370	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.000000	0	0	97,768	0	90.08
91.00	09100	EMERGENCY	0.000000	3,961,191	0	8,707,461	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	438,106	0	4,479,694	0	92.00
200.00		Total (lines 50 through 199)		22,113,675	11,329	98,482,683	86,346	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 7:01 am

Title XVIII | Hospital | PPS

		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	0.212395	6,801,082	0	0	1,444,516	50.00
51.00	05100	RECOVERY ROOM	0.425932	316,386	0	0	134,759	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.112786	23,598,387	6,504	0	2,661,568	54.00
60.00	06000	LABORATORY	0.128061	5,443,081	1,084	0	697,046	60.00
65.00	06500	RESPIRATORY THERAPY	0.367819	1,507,466	0	0	554,475	65.00
66.00	06600	PHYSICAL THERAPY	0.471724	23,201	0	0	10,944	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373116	8,764	0	0	3,270	67.00
68.00	06800	SPEECH PATHOLOGY	0.309401	4,896	0	0	1,515	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121700	3,467,552	0	0	422,001	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3.520907	265,052	0	0	933,223	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.127321	1,959,811	0	0	249,525	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.232349	38,733,869	53	5,742	8,999,776	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.510435	186,803	0	0	95,351	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.230469	399,040	0	0	91,966	90.01
90.02	09002	DIABETES CLINIC	10.975740	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	6.210692	0	0	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0.532367	2,482,370	0	0	1,321,532	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.365476	97,768	0	0	35,732	90.08
91.00	09100	EMERGENCY	0.104046	8,707,461	0	0	905,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.316848	4,479,694	0	0	1,419,382	92.00
200.00		Subtotal (see instructions)		98,482,683	7,641	5,742	19,982,557	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		98,482,683	7,641	5,742	19,982,557	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/31/2024 7:01 am

Title XVIII | Hospital | PPS

		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	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	734	0	54.00
60.00	06000	LABORATORY	139	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12	1,334	73.00
76.00	03020	CARDIAC	0	0	76.00
76.01	03160	CARDIOPULMONARY	0	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	90.04
90.05	09005	PRIME TIME	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	90.06
90.07	04951	ONCOLOGY	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	90.08
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	885	1,334	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	885	1,334	202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 7:01 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,673	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,673	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)	5,011	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	935	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,383,332	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,383,332	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,383,332	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,543.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,442,799	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,442,799	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 7:01 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	13,237,910	6,140	2,156.01	1,858	4,005,867	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,289,266	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)	9,737,932	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)	849,877	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	369,887	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,219,764	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,518,168	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)	3,662	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,543.10	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 7:01 am
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,650,832	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,363,270	13,383,332	0.176583	5,650,832	997,841	90.00
91.00	Nursing Program cost	0	13,383,332	0.000000	5,650,832	0	91.00
92.00	Allied health cost	0	13,383,332	0.000000	5,650,832	0	92.00
93.00	All other Medical Education	0	13,383,332	0.000000	5,650,832	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 7:01 am

		Title XIX	Hospital	Cost
	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,673	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,673	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)	5,011	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	160	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,383,332	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,383,332	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,383,332	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,543.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	246,896	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)	246,896	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/31/2024 7:01 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	13,237,910	6,140	2,156.01	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)	147,940	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)	394,836	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)	3,662	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,543.10	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/31/2024 7:01 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,650,832	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,363,270	13,383,332	0.176583	5,650,832	997,841	90.00
91.00	Nursing Program cost	0	13,383,332	0.000000	5,650,832	0	91.00
92.00	Allied health cost	0	13,383,332	0.000000	5,650,832	0	92.00
93.00	All other Medical Education	0	13,383,332	0.000000	5,650,832	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/31/2024 7:01 am
	Title XVIII	Hospital	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		917,877		30.00
31.00	03100	INTENSIVE CARE UNIT		5,113,125		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.212395	2,490,478	528,965	50.00
51.00	05100	RECOVERY ROOM	0.425932	207,889	88,547	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.112786	3,096,219	349,210	54.00
60.00	06000	LABORATORY	0.128061	4,401,330	563,639	60.00
65.00	06500	RESPIRATORY THERAPY	0.367819	789,309	290,323	65.00
66.00	06600	PHYSICAL THERAPY	0.471724	219,623	103,601	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373116	174,241	65,012	67.00
68.00	06800	SPEECH PATHOLOGY	0.309401	83,245	25,756	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121700	1,506,407	183,330	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3.520907	153,377	540,026	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.127321	695,522	88,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.232349	3,876,940	900,803	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.510435	0	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.230469	0	0	90.01
90.02	09002	DIABETES CLINIC	10.975740	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	6.210692	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	90.06
90.07	04951	ONCOLOGY	0.532367	19,798	10,540	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.365476	0	0	90.08
91.00	09100	EMERGENCY	0.104046	3,961,191	412,146	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.316848	438,106	138,813	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		22,113,675	4,289,266	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		22,113,675		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/31/2024 7:01 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		314,158		30.00
31.00	03100	INTENSIVE CARE UNIT		163,057		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.212395	200,399	42,564	50.00
51.00	05100	RECOVERY ROOM	0.425932	18,354	7,818	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.112786	42,054	4,743	54.00
60.00	06000	LABORATORY	0.128061	132,411	16,957	60.00
65.00	06500	RESPIRATORY THERAPY	0.367819	28,910	10,634	65.00
66.00	06600	PHYSICAL THERAPY	0.471724	3,283	1,549	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373116	2,872	1,072	67.00
68.00	06800	SPEECH PATHOLOGY	0.309401	2,122	657	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121700	22,013	2,679	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3.520907	4,336	15,267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.127321	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.232349	133,363	30,987	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.510435	0	0	76.01
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.629342	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.230469	124	29	90.01
90.02	09002	DIABETES CLINIC	10.975740	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	6.210692	0	0	90.04
90.05	09005	PRIME TIME	0.000000	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	90.06
90.07	04951	ONCOLOGY	0.532367	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.365476	0	0	90.08
91.00	09100	EMERGENCY	0.104046	124,793	12,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.316848	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		715,034	147,940	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)		715,034		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Date/Time Prepared: 5/31/2024 7:01 am

		Title XVIII	Hospital	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			4,724,623	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			1,734,504	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			41,695	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			8,184	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			102.97	4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)			0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			1.68	30.00
31.00	Percentage of Medicaid patient days (see instructions)			17.62	31.00
32.00	Sum of lines 30 and 31			19.30	32.00
33.00	Allowable disproportionate share percentage (see instructions)			5.29	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 7:01 am
	Title XVIII	Hospital	PPS

			1.00	
34.00	Disproportionate share adjustment (see instructions)		85,422	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	891,326	692,931	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	666,663	174,179	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	840,842		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	7,435,270		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	7,435,270	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	524,244	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	12,916	53.00
54.00	Special add-on payments for new technologies	39,320	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	11,329	58.00
59.00	Total (sum of amounts on lines 49 through 58)	8,023,079	59.00
60.00	Primary payer payments	3,400	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	8,019,679	61.00
62.00	Deductibles billed to program beneficiaries	916,055	62.00
63.00	Coinsurance billed to program beneficiaries	25,200	63.00
64.00	Allowable bad debts (see instructions)	22,860	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	14,859	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22,860	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	7,093,283	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-9,175	70.93
70.94	HRR adjustment amount (see instructions)	-79,217	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Date/Time Prepared: 5/31/2024 7:01 am

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Line	Description	FFY (yyyy) 0	Amount 1.00	Line
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2023	346,451	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2024	128,115	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,479,457	71.00
71.01	Sequestration adjustment (see instructions)		149,589	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		7,132,328	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		197,540	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		124,483	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 5/31/2024 7:01 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,724,623	0	4,724,623		4,724,623	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,734,504	0		1,734,504	1,734,504	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	41,695	0	41,695		41,695	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	8,184	0		8,184	8,184	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0529	0.0529	0.0529	0.0529		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	85,422	0	62,483	22,939	85,422	11.00
11.01	Uncompensated care payments	36.00	840,842	0	666,663	174,179	840,842	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,435,270	0	5,495,464	1,939,806	7,435,270	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,435,270	0	5,495,464	1,939,806	7,435,270	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2024 7:01 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	524,244	0	381,382	142,862	524,244	16.00
17.00	Special add-on payments for new technologies	54.00	39,320	0	39,320	0	39,320	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	5,916,166	2,082,668	7,998,834	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	489,221	0	355,341	133,880	489,221	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	15,503	0	11,863	3,640	15,503	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0399	0.0399	0.0399	0.0399		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	19,520	0	14,178	5,342	19,520	25.00
26.00	Total prospective capital payments (see instructions)	12.00	524,244	0	381,382	142,862	524,244	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.058560	0.061515		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			346,451		346,451	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				128,115	128,115	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/31/2024 7:01 am
	Title XVIII	Hospital	PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,724,623	4,724,623		4,724,623	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,734,504		1,734,504	1,734,504	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	41,695	41,695		41,695	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	8,184		8,184	8,184	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0529	0.0529	0.0529		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	85,422	62,483	22,939	85,422	11.00
11.01	Uncompensated care payments	36.00	840,842	666,663	174,179	840,842	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,435,270	5,495,464	1,939,806	7,435,270	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,435,270	5,495,464	1,939,806	7,435,270	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	524,244	381,382	142,862	524,244	16.00
17.00	Special add-on payments for new technologies	54.00	39,320	39,320	0	39,320	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			5,916,166	2,082,668	7,998,834	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/31/2024 7:01 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	489,221	355,341	133,880	489,221	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	15,503	11,863	3,640	15,503	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0399	0.0399	0.0399		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	19,520	14,178	5,342	19,520	25.00
26.00	Total prospective capital payments (see instructions)	12.00	524,244	381,382	142,862	524,244	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	346,451	346,451		346,451	28.00
29.00	Low volume adjustment on or after October 1	70.97	128,115		128,115	128,115	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-9,175	0	-9,175	-9,175	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-79,217	-73,840	-5,377	-79,217	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 7:01 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,219	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	19,896,211	2.00
3.00	OPPS or REH payments	14,535,055	3.00
4.00	Outlier payment (see instructions)	81,873	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 including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	86,346	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,219	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	13,383	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)	13,383	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)	13,383	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	11,164	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)	2,219	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)	14,703,274	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	1,340	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,489,061	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)	12,215,092	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	12,215,092	30.00
31.00	Primary payer payments	1,843	31.00
32.00	Subtotal (line 30 minus line 31)	12,213,249	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)	53,993	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	35,095	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	53,993	36.00
37.00	Subtotal (see instructions)	12,248,344	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)	12,248,344	40.00
40.01	Sequestration adjustment (see instructions)	244,967	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	12,026,359	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-22,982	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 7:01 am
	Title XVIII	Hospital	PPS

		1.00	
94.00	Total (sum of lines 91 and 93)	0	94.00
		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: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/31/2024 7:01 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,076,784		11,883,768	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	12/31/2023	20,844	12/31/2023	112,991	3.01
3.02		08/30/2023	34,700	03/30/2023	29,600	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)		55,544		142,591	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)		7,132,328		12,026,359	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		197,540		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		22,982	6.02
7.00	Total Medicare program liability (see instructions)		7,329,868		12,003,377	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/31/2024 7:01 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (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 | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-3 Part VII Date/Time Prepared: 5/31/2024 7:01 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	394,836		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	394,836	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	394,836	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	477,215		8.00
9.00	Ancillary service charges	715,034	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,192,249	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,192,249	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	797,413	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	394,836	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	394,836	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	394,836	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	394,836	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	394,836	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	394,836	0	40.00
41.00	Interim payments	724,664	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-329,828	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/31/2024 7:01 am
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

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

Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/31/2024 7:01 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	8,448,795	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	20,243,822	0	0	0	4.00
5.00	Other receivable	9,186,044	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	8,584,446	0	0	0	7.00
8.00	Prepaid expenses	2,907,061	0	0	0	8.00
9.00	Other current assets	123,285,242	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)	172,655,410	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	29,420,345	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	203,358,816	0	0	0	15.00
16.00	Accumulated depreciation	-213,071,717	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	109,098,409	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	128,805,853	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	35,497,003	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	35,497,003	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	336,958,266	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	9,044,271	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,125,069	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,469,943	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	24,639,283	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,749,681	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,749,681	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	26,388,964	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	310,569,302				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)	310,569,302	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	336,958,266	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/31/2024 7:01 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		301,206,243		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,363,059				2.00
3.00	Total (sum of line 1 and line 2)		310,569,302		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)		310,569,302		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)		310,569,302		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/31/2024 7:01 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	12,712,231		12,712,231	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,712,231		12,712,231	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	25,037,538		25,037,538	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)	25,037,538		25,037,538	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	37,749,769		37,749,769	17.00
18.00	Ancillary services	42,102,300	359,847,354	401,949,654	18.00
19.00	Outpatient services	8,620,466	97,192,108	105,812,574	19.00
20.00	RURAL HEALTH CLINIC	0	853,313	853,313	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	1,198,747	550,096	1,748,843	26.00
27.00	PHYSICIAN PRACTICES/DIETARY REV	0	16,453,398	16,453,398	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	89,671,282	474,896,269	564,567,551	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		196,413,438		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)		196,413,438		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/31/2024 7:01 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	564,567,551	1.00
2.00	Less contractual allowances and discounts on patients' accounts	404,437,140	2.00
3.00	Net patient revenues (line 1 minus line 2)	160,130,411	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	196,413,438	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-36,283,027	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	15,829,344	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	20,389,551	24.00
24.01	OTHER NON-OPERATING INCOME	3,130,544	24.01
24.02	CAPITAL CONTRIBUTIONS	-9,107,087	24.02
24.03	TRANSFER	15,502,591	24.03
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	45,744,943	25.00
26.00	Total (line 5 plus line 25)	9,461,916	26.00
27.00	OTHER HOSPITAL EXPENSE	98,857	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	98,857	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,363,059	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0037	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/31/2024 7:01 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	489,221	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	15,503	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	30.95	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	1.68	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	17.62	8.00
9.00	Sum of lines 7 and 8	19.30	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.99	10.00
11.00	Disproportionate share adjustment (see instructions)	19,520	11.00
12.00	Total prospective capital payments (see instructions)	524,244	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0037 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1
Component CCN: 15-3987 | | Date/Time Prepared: 5/31/2024 7:01 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	6,053	0	6,053	0	6,053	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	139,454	0	139,454	0	139,454	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	40,642	0	40,642	0	40,642	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	97,394	0	97,394	0	97,394	9.00
10.00	Subtotal (sum of lines 1 through 9)	283,543	0	283,543	0	283,543	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	15,032	15,032	-52	14,980	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	15,032	15,032	-52	14,980	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	283,543	15,032	298,575	-52	298,523	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	31,632	31,632	-31,632	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	31,632	31,632	-31,632	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	175,618	175,618	0	175,618	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	175,618	175,618	0	175,618	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	283,543	222,282	505,825	-31,684	474,141	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/31/2024 7:01 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	6,053	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	139,454	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	40,642	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
7.10	Marriage and Family Therapist			7.10
7.11	Mental Health Counselor			7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	97,394	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	283,543	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	14,980	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,980	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	298,523	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-47,950	127,668	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-47,950	127,668	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-47,950	426,191	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-0037 | Component CCN: 15-3987 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/31/2024 7:01 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.19	4,015	2,100	2,499		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.19	4,015		2,499	4,015	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.19	4,015			4,015	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	298,523	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	298,523	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	127,668	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	110,835	15.00
16.00	Total overhead (sum of lines 14 and 15)	238,503	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	238,503	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	238,503	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	537,026	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/31/2024 7:01 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		537,026	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		5,463	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		531,563	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,015	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,015	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		132.39	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	126.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	375	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	47,250	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	47,250	16.00
16.01	Total program charges (see instructions)(from contractor's records)		53,238	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		9,009	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,996	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		26,982	16.04
16.05	Total program cost (see instructions)	0	34,978	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,527	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		7,740	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		34,978	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,123	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		38,101	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		38,101	26.00
26.01	Sequestration adjustment (see instructions)		762	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		33,072	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		4,267	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2023 To 12/31/2023	Worksheet M-4 Date/Time Prepared: 5/31/2024 7:01 am
	Title XVIII	RHC I	Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	283,543	283,543	283,543	283,543	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000269	0.009832	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	76	2,788	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	145	28	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	221	2,816	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	298,523	298,523	298,523	298,523	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	238,503	238,503	238,503	238,503	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000740	0.009433	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	176	2,250	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	397	5,066	0	0	10.00
11.00	Total number of injections/infusions (from your records)	4	146	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	99.25	34.70	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	90	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	3,123	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		5,463	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		3,123	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/31/2024 7:01 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		33,072	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		33,072	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		4,267	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		37,339	7.00

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